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AUTHOR	Wolkstein, Eileen; Richman, Alex
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ABSTRACT

An outline of vocational rehabilitation of the ex-addict is presented, with emphasis placed on the development of treatment plans, counselor inservice training, and clinical procedures. Discussion is based on the Beth Israel Medical Center (BIMC) programs of Methadone Maintenance Treatment and Alcohol Treatment. Section 1, Proceedings, defines goals for vocational rehabilitation and discusses the ex-addict, counseling techniques, and counseling forms developed by the BIMC program. The needs of the patient are stressed in planning systematic treatment, and a summary of sources of influence on the client-counselor relationship are provided. Section 2, Clinical Profiles, examines three cases in terms of the impact clinical procedures have had on the patients for whom problems were assessed and plans developed. Each case study discusses rationale for selection, patient profile, plan formulation, initial and revised treatment, and followup, where applicable. The BIMC project is reviewed. Appendixes discusses project background, a vocational rehabilitation program within the Methadone Maintenance Treatment, the Alcohol Treatment Programs, and Drug Addiction Service Staff participation in the research project. Vocational Structured Interview and Semantic Differential Forms, comments, and an editorial seminar agenda and its participants are also appended. (LH)

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The State of the Art

VOCATIONAL REHABILITATION OF THE DRUG ABUSER

TREATMENT PLANNING AND CLINICAL SUPERVISION

NO. 5 IN A SERIES

YOUTH PROJECTS, INC.

and

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
Washington, D.C.

1975

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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For Information:

Dr. Herbert H. Leibowitz
Research and Demonstration Analyst
Rehabilitation Services Administration
50 Fulton St.
San Francisco, California 94101
Department of Health, Education, and Welfare

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No. 4 — GAINFULLY EMPLOYED

No. 5 — TREATMENT PLANNING AND CLINICAL SUPERVISION

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Ellen Weisstein

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A special acknowledgement is made to the staff and consultants who made this difficult project an easier one to execute. Many of the participants at the Seminar performed duties far beyond those asked of them. In addition to our thanks, we extend our best wishes to them in the difficult job of guiding the drug-abusing client towards a more fully-realized life.

To Anne Gay, Grants Administrator of Youth Projects, Inc., and other helpful members of the Youth Projects staff, a sincere thank you.

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VOCATIONAL REHABILITATION OF THE DRUG ABUSER

TREATMENT PLANNING AND CLINICAL SUPERVISION

Authors:
Eileen Wolkstein, M.A.
Director, Vocational Rehabilitation Department
Morris J. Bernstein Institute
Beth Israel Medical Center

Alex Richman, M.D.
Chief, Utilization and Review Activities
Department of Psychiatry
Beth Israel Medical Center
Professor of Psychiatry, Mount Sinai School of Medicine
of the City University of New York

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The project that made this report possible was proposed and developed to introduce new directions and a creative approach to the Vocational Rehabilitation of ex-addicts. It was designed to facilitate qualitative improvement in the vocational services available to the ex-addict.

Dale Williamson

Director — Office of Rehabilitation Services

H.E.W. — O.H.D.

Region 9, San Francisco, Calif.

Dr. Herbert Leibowitz

Research & Training Consultant

Office of Rehab. Services

H.E.W. — O.H.D. — Region 9

San Francisco, Calif.

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

JUL 9 1973

Although drug abuse is an age-old problem in many parts of the world and certainly not a new one to this country, our current perception of the problem is new. We have moved from a view of drug abuse as almost exclusively a law enforcement problem to one where health has at least equal billing. In fact, the Drug Abuse Office and Treatment Act of 1972, signed by the President on March 21 of that year, contains as a mandate that "...administering agencies construe drug abuse as a health problem."

This new dimension to our government's approach toward the victims of drug abuse brings the role of the Department of Health, Education, and Welfare more sharply into play. Our overall goals are the elimination of drug abuse as a major social concern in our Nation, the rehabilitation and employment of the drug abuser, and the eradication of those conditions which have allowed the crisis to reach such pervasive proportions.

This Conference has made a valuable contribution toward identifying the proper role of rehabilitation in securing the return to productivity for those who have been victims of drug abuse.

Secretary

EXECUTIVE OFFICE OF THE PRESIDENT
SPECIAL ACTION OFFICE FOR DRUG ABUSE PREVENTION
WASHINGTON, DC 20500

JUL 9 1973

Our experience treating drug addicts has taught us that the elimination of illicit drug use by itself, is not enough. A program can release a model patient, after months or even years of treatment. But if he goes back to the same environment, with the same limited capacities he had before, he is far too likely to go back to drugs as well.

Two ingredients, other than drug abuse treatment, are essential for an addict to give up his habit: he must have the will to give it up, and he must have the means to do so.

The will comes largely from within the individual; the means often comes from outside. For some addicts, what is needed most is counseling and personal support. For others it may be health care and a balanced diet. But most of those who are ground down in the desperate hell of addiction also need new tools and opportunities to use them.

The vast majority of heroin addicts in the United States have dropped out of school and have little or no work experience.

The need for education, job training and job placement is often apparent. The question is how to provide these services most effectively. A person who invests two or three years in completing his high school equivalency, or taking a vocational education course, or learning some job-related skill, must have an assurance that at the end of that time a new life—a new job—awaits him.

At the present time the Special Action Office is encouraging experimentation with a number of approaches to providing jobs and education to ex-addicts.

— Some treatment programs are experimenting with specialized job placement personnel who serve as intermediaries between treatment programs and potential employers. These personnel are responsible for educating prospective employers about drug addiction, for arranging interviews for ex-addicts seeking jobs, and in some cases for working in a follow-through capacity once an ex-addict is employed.

— Other treatment programs are using a referral system, under which job-ready patients are referred to state and local employment agencies or to job-training or education programs.

— Some treatment facilities provide both education and vocational training as part of their general supportive services.

In conjunction with these various approaches, the Special Action Office is moving on many fronts to overcome the discrimination which presently exists in the employment of ex-addicts:

— We have worked with the Civil Service Commission to develop standard guidelines for implementing Section 413 of the Drug Abuse Prevention Act. These include non-discrimination against ex-addicts in consideration for employment in non-sensitive government positions; opportunities for treatment without loss of employment; and a more "positive policy" of providing government employment opportunities to ex-addicts.

— Where agencies and departments of government are found to be lax in implementing these new guidelines, the Special Action Office has tried to work with the organizations to help them develop reasonable and constructive programs.

— The Special Action Office has also established a Task Force on Employment and Industry. Staffed by SAO personnel, the Task Force has begun working with industry and labor to create greater understanding of drug addiction and the ways in which employment of ex-addicts can be implemented. It is expected that guidelines for industry and labor, as well as for state and local governments can be developed.

In some cases, however, simply making the skills and opportunities available to ex-addicts is not enough. For those ex-addicts who have no work experience, who have never kept to a regular schedule or exercised personal or cooperative responsibilities, something more is required if they are to become productive members of society. For such people, we are experimenting with sheltered work. Special subsidized workshops are established where ex-addicts may learn to apply their new vocational skills in a work environment. It is felt that by working with other individuals who likewise have few job skills, the tensions and pressures of employment will be reduced. Only after the ex-addict has achieved a reasonable level of competence and stability will he be ready to compete in the open job market.

In promoting jobs for ex-addicts, we cannot ask that they will be given preference over other persons seeking work. But we can ask that they be given an equal opportunity, commensurate with their training and skills, to become productive members of our society. We must also do more to equip the ex-addicts with the skills needed to use these opportunities.

Robert L. DuPont M.D.

Robert L. DuPont, M.D.
Director

TREATMENT PLANNING AND CLINICAL SUPERVISION

EXPANDED INDEX

Vocational Rehabilitation of the Ex-Addict

A Research Demonstration of Selected Techniques of Patient Assessment, Treatment Planning and Supervision.

Introduction

A discussion of the need for qualitative clinical approaches in the vocational rehabilitation of the ex-addict. Considerations include:

- defining goals in vocational rehabilitation
- defining goals in vocational rehabilitation
- clinical process
- the future of vocational rehabilitation

Project Results

A description of the project results under the heading of Value to patient

Clinical Procedures

A description of the research project under the headings of:

Vocational Rehabilitation Staff

Tools: Vocational Structural Interview Form (VSIF) for diagnostic assessment

Semantic Differential Form (SD) for attitude assessment

Systematic Treatment Planning

A discussion of the rationale for the research project as related to the need for systematic planning in vocational rehabilitation.

Clinical Supervision

A discussion of the dynamics of supervision during the research project, including a general introduction and specific material under the headings of:

Staff reactions to project

Staff reaction to the VSIF and SD

A closer look at staff reactions

Summary of key issues in counselling and the supervisory process

Clinical Profiles

Three clinical profiles of research project patients. The Clinical Profiles section includes:

- Introduction — a general discussion of the case studies
- First Clinical Profile — a patient who has been in treatment for three months, unemployed, wants to work
- Second Clinical Profile — a patient who has been in treatment one year, unemployed, wants to work
- Third Clinical Profile — a patient who has been in treatment more than one year, working, wants a job change.

Each Clinical Profile includes a description of rationale for selection, a short patient profile, an initial treatment plan, and discussion of the plan. In addition, the First Clinical Profile includes a revised treatment plan, and the Third Clinical Profile includes a three-month follow-up.

APPENDICES:

Appendix A: Background

A discussion of the background including major areas of impetus for the project:

- Traditional attitudes
- Methadone maintenance
- Conflict and coordination within treatment programs

Appendix B: A Closer Look at Vocational Rehabilitation within a Methadone Maintenance Program

A discussion and description of a vocational rehabilitation program within the Methadone Maintenance Treatment Program at Beth Israel Medical Center, divided into the following headings:

- Introduction
- Methadone maintenance treatment: A definition
- The function of vocational rehabilitation counselling
- Training professional and non-professional staff of other disciplines in techniques of vocational rehabilitation counselling
- Delivery of vocational rehabilitation services
- Identification and evaluation techniques
- Community attitudes

Appendix C: Alcohol Treatment Program

A description of the Alcohol Treatment Program vocational rehabilitation services, which were modeled after the Methadone Maintenance Treatment Program

Appendix D: Drug Addiction Service Staff Participation in Research Project

A description and discussion of DAS staff participation in the research project, with special emphasis on the similarities and differences between DAS procedures and the procedures of the research in general

Appendix E: Vocational Structured Interview Forms for

- Methadone Maintenance Treatment Program
- Alcohol Treatment Program
- Drug Addiction Service

Appendix F: Semantic Differential Form

References

COMMENTS

These volumes reflect a concern on the part of rehabilitation services personnel . . . both counselors and administrators . . . to better understand their role in the vocational rehabilitation of drug abusers.

We have attempted to derive from current theory and practice in the field of vocational rehabilitation a base for defining a state of the art statement.

These volumes reflect only a beginning in the process of truly understanding the dimensions of this problem. We hope that they will introduce you to the constellations of factors that enter into the task of viable vocational rehabilitation programming for the drug abuser.

We hope that some of the words will engage you in furthering this process. . . of bringing effective social and vocational services to the addicted person.

Herbert H. Leibowitz

TREATMENT PLANNING AND CLINICAL SUPERVISION

NO. 5 IN A SERIES

The Buck Stops Here

It's going to come either from NIMH on the basis of agreements worked out between State Rehab directors and NIMH treatment center directors, or it's going to come out of the state plan where it's built in . . .

The State Directors . . these are the people who are going to change this thing . . .

It almost sounds as if we're calling for the kind of revitalization of a profession that has, somehow or other, become pretty encrusted . . Is there a possibility of revitalizing this profession through some kind of middle management retraining?

In my own state, I'm way down the totem pole. I'm the one who is sent to all of these various drug and public offender conferences.

I think the counselors, naturally, know a lot more about what's going on than the Voc Rehab Leadership . . .

Defining goals in vocational rehabilitation

In our society, where work is both role and function, rehabilitation must include meaningful work. While most of the helping professions are concerned with having their patients "go to work", vocational rehabilitation is the discipline primarily concerned with enhancing the meaning of work to the individual.

The development of a treatment plan is not generally stressed in graduate or training programs. Without emphasis on developing and implementing comprehensive treatment plans, vocational rehabilitation can be diffuse and ineffective, unsatisfying, and may often foster inherently hostile attitudes toward patient care and professional roles. However, with the "focus" provided by a treatment plan, it becomes possible to consider patient care in perspective, to provide more concise material susceptible to supervision, and to allow for assessment of the course of treatment.

A treatment plan is "a written report which states the immediate and long-term goals of treatment and defines what the therapist and patient are going to do relative to each other . . ."[1]

This volume describes a format for in-service training and group supervision wnich focuses on the treatment plan as an

integral part of staff function. Personal data are needed for development of a treatment plan. Procedures for history-taking and attitude assessment, which are not stereotyped, promote interaction and provide concise records of patients' backgrounds, and current status as they relate to potential development.

These clinical tools are essential to evaluating the patient's abilities, problems, and current goals in order to develop a vocational plan. In-service training is directed toward increasing the counselor's awareness of and opportunity to express creativity in developing a comprehensive treatment plan. These clinical approaches enhance the quality of patient care.

The former addict as a vocational rehabilitation (VR) client

In a drug abuse treatment population, many patients have a limited prior working experience, little evidence of positive attitudes toward work, and a general orientation that does not include work as a clearly defined focus in life. Patients vary from those with a specific goal to those who are unstructured and unaware of any sense of direction. The counselor, in trying to strike a balance, can too often lose sight of a clear direction and, in the process of trying to engage the patient and attempting to make constructive changes, can lose clarity of purpose and move away from clearly defined goals.

Traditionally VR clients come from backgrounds that are work oriented and tend to be separated from the work force primarily because of their disability. This creates less of a distance from society in terms of a total life style and is not viewed by the community with such suspicion and hostility as is directed toward the drug abuser. Because of the perceived differences, the VR counselor may become less concrete, systematic and goal oriented and succumb to the pressure to accept the patient's interpretation of reality. It is not only ex-addict clients who are often unreliable in keeping appointments, timid about going to interviews, reluctant to accept the routine of menial jobs, and lacking in ambition. Similar to other VR clients, there is often evidence of a fear of returning to work, feelings of inadequacy and helplessness.

Approximately 15 percent of patients are able to meet their vocational goals with a minimum of assistance, and for these individuals VR services are not indicated. For an additional 15 percent, vocational services are inappropriate because of repeated abuse and chronic behavioral disturbance. Attention is therefore directed to the remaining 70 percent. There are two basic patient types within this group, those who are employed but are dissatisfied with their employment and the quality of their lives, and those with sporadic and unsuccessful work his-

tories, negative vocational experience and a panoply of personal-social problems.

The counselor's efforts are directed toward exploring the reality of the presenting requests and the patient's potential for meeting expressed goals. Within the boundaries of the counselling contract, the subsequent counselling is directed toward helping the individual explore his/her reasons for destructive behavior and find alternate modes of behavior. The objectives of counselling are to help the patient establish an identity as an employee and to secure and maintain suitable employment.

Requests for job upgrading should be approached with an emphasis on the patient's total life situation. Frequently, patients attempt to change all aspects of their life simultaneously, often after a significant positive experience. Counselling is directed at exploring the reasons for change and the best possible means of achieving expressed goals. Vocational or academic training programs may be provided. An alternate means of achieving job upgrading may be through encouraging patients to work toward promotion into a more responsible position.

Clinical process

The goal of the vocational rehabilitation counselor (VRC) is not solely job placement. Far more important, the counselor must help the addict develop his/her personal satisfaction, social role and earning ability. The **meaning** of work must be enhanced for the addict. The VRC, in order to achieve these goals, acts as a lever, focusing on the dimensions of intrapsychic development, social rehabilitation and work behavior.

Frequently great pressure is put on the VRC to gloss over this clinical planning process. When a patient requests some form of vocational assistance, the tendency may be to respond only to **that** need. The pressure is magnified when the patient is in a state of crisis and "the" job seems to be the salvation. Unfortunately, many former drug addicts are chronically in a crisis situation.

> For example: A patient says he **has** to get a job. An impatient judge and a pregnant wife apply additional pressure. Everybody else has failed. The VRC **must** help.

It may be difficult, at that point, for the VRC to resist the crisis and the pressure. On the other hand, to attempt to get a job for the patient may not only be totally unrealistic but may lead to the creation of increased immediate problems. To try to assess the patient's needs objectively and systematically may seem far-fetched. However, formulating a picture of the patient and assessing his needs, although difficult, are requisite to treatment planning necessary for quality VR. The outcome of this assessment may well be very short-term goals. Never-

theless, these goals will exist within the context of reality and help to focus the counselor and patient toward future vocational planning.

A need for definition

Concurrently, vocational rehabilitation has become more accepted in addiction treatment. Treatment programs are requesting a means for meeting patients' vocational needs.

The community, including business and industry, is becoming involved in the VR of addicts in treatment. Various levels of government and private foundations have supported the expansion of vocational services and encourage the leadership and professional role of VR.

With the increased focus on the employment of the ex-addict, greater numbers of staff are directing their efforts toward developing expertise in the area of job development. Under pressure for guidance from these individuals, it is important, perhaps even urgent, that VR declare its goals and make the clinical procedures visible.

Towards the future of vocational rehabilitation

Perhaps it will be a relief to know that in certain programs VR has already developed an impressive record in addiction treatment.[2, 3] It is hoped that by considering the skills of VR methodically and systematically, VR can be helped to meet these expanding needs, the concepts of VR can be taught to others, and the benefits can be brought to greater numbers of addicts.

The procedures described in this volume are part of that process of systemization and self-examination. Although this work concerns VR of the drug abuser, and was stimulated by the needs of drug abuse programs, it is felt that the efforts of systemization are applicable for other psycho-social disability groups. The principles are the same; the tools are adaptable.

In some situations the role of the VRC is poorly understood, not visible or vague, counselling is without goals and lacks the tempo of progress. The VRC often feels isolated, overwhelmed, frustrated and disappointed. Referrals are inappropriate, employers are resistant and patients are demanding. Relationships based on trust and acquired through prolonged, diffuse counselling sessions are often fragile and tenuous.

When these problems surface in the context of program planning, in-service training and supervision, the blame for clinical failure is placed on the patient rather than on the interaction. A myriad of feelings often prevents a focus on the patient.

The key elements in this procedure include the diagnostic tools of the Vocational Structured Interview Form, which is an

interview guide (See Appendix E) and an attitude assessment based on the Semantic Differential (See Appendix F). These are used to develop a written treatment plan. The tools and plan are used as the basis for clinical supervision, in-service training or consultation.

Clinical Procedures

The process to be described has been developed to enhance VR services by emphasizing individual patient assessment, treatment planning, and the supervisory process.

In our setting we have nine professionally trained VRCs who are full-time employees of Beth Israel Medical Center working in the Methadone Maintenance Treatment and Alcohol Treatment programs. Each counselor has a Master's degree in VR and a minimum of one year's professional experience. Each is involved in two hours of weekly group supervision.

Assessment Tools: Vocational Structured Interview Form

To facilitate treatment planning in the VR of drug abusers, we have developed a structured interview procedure which is used for initial diagnostic assessment. It was hypothesized that such an interview outline would encourage structure in meetings with patients as well as serve as a device which could be used in treatment planning.

The form selected had been initiated by the department for a research project conducted in 1971[4]. It had been developed to record patient information in a systematic fashion, but had not been used in clinical supervisory sessions. The form was converted for such use with minimal revisions. The wording is appropriate for our patients, the sequence is clinically sound, and there is sufficient space available to record findings.

A brief discussion of the way in which the form was developed may help give an understanding of the content.

The VSIF is intended to focus the diagnostic interview and to facilitate the recording of clinical information pertinent to the provision of VR services. It was developed to structure the interview situation and provide systematic information on a wide variety of relevant vocational issues in a patient's history.

The VSIF was developed by the VR staff who proceeded by selecting topics appropriate for the initial VR interview. The purpose of the initial interview is the determination of the vocational and personal/social dimensions necessary for assessment and planning. Factors of expediency and comprehensiveness were considered. Although the time required to complete the form ranged from an hour to an hour and a half, length became a secondary factor as appreciation of its clinical value increased.

Initially there were negative staff reactions to the time necessary for completion, but as they worked with the VSIF, time and length became less significant. The comprehensiveness of the material gained in one interview reduced the necessity to focus on basic historical information in subsequent meetings. The process of completing the VSIF was found to stimulate the patient into thinking about many aspects of vocational development.

Attitude Assessment

The second tool we have developed for our clinical procedures is based on the semantic differential.[5, 6]

The staff selected paired words which relate to and are significant in VR. Some of the words were general and might be used in other fields; some pairs of words — skilled-unskilled, experienced-inexperienced — are directly related to the concerns of the VRC.

This attitude scale provides a more specific means and vocabulary for describing a patient. It is used to elicit staff attitudes towards specific patients.

Used in conjunction with the VSIF just described, the semantic differential form provides additional information for comprehensive patient assessment and development of a treatment plan.

In order to describe a patient by one of the words of a pair, it is necessary to consider the ingredients of each word. For example, a patient may be described as motivated (rather than unmotivated) to go to work. Because "motivation" may generate differing reaction, the counselor has to consider "motivation" in more specific and descriptive ways. In the process of being more descriptive, it becomes necessary for the counselor to explore feelings, attitudes and assumptions in order to assign the appropriate dimensions of a concept to a patient.

Discussions surrounding this type of attitude assessment lead to a clearer understanding about distinctions in degree in assessing accomplishments in different life style environments.

The semantic differential form helps counselors to become more sensitive to and understanding of contradictions in a patient's presentation of self. It is apparent that the counselor may need to legitimize a contradiction rather than explore the implications. Once the counselor is clearly aware of the contradictions, he/she can better help the patient to understand them.

Systematic treatment planning

All forms of therapy are interventions; they differ only in means of developing and carrying out the plan. In theory, treatment intervention requires systematized planning; in re-

ality, little attention is given to systematized planning of treatment. The consequences of failure to formulate a treatment plan are sloppiness in counselling, little objectivity, and, seemingly, an over-abundance of emotion, contradiction, competition and lack of scientific inquiry.

An integral part of treatment planning is the assessment of the needs of the patient. The assessment process includes an accurate formulation of a patient profile, including achievements and limitations. The patient has to be seen as objectively and realistically as possible. The many barriers to objectivity, whether or not they are consciously constructed, are deterrents to effective planning, and to the rehabilitation of the patient. Understanding and overcoming these barriers contribute to the counselor's over-all assessment and treatment of the patient.

The availability of a written plan and specific goal orientation give counselors the chance to periodically reassess the patient's growth and needs, as well as to make the plan visible to other members of the team. The implementation of the plan becomes a means of remaining constantly in touch with a carefully thought-out approach and facilitates a closer and more realistic clinical procedure. It becomes possible to explore the reasons for individual responses and, ultimately, to arrive at a comprehensive perspective on the patient. [7, 8, 9]

Clinical Supervision

The ability of the VRC to treat addicts demands both technical skill and personal integration. The job is challenging, often frustrating, and frequently laden with pressure and disappointment. And yet it can be highly gratifying.

In order to maintain a balance of the parts, and indeed to increase the opportunities for gratification, the counselor is provided with the opportunity for supervision. Supervision is directed at improving technical skills and resolving personal conflicts and obstacles to learning. For the counselor to take full advantage of supervision, a willingness to be open to growth and change is required. Although the prospect of such personal confrontation may be alarming at first, the counselor, in realizing the possible benefits, becomes receptive to addressing needs of the clients.

Supervision seeks to reduce the possibility that personal obstacles may be transferred to the client and restrict opportunities, punish behavior or exaggerate permissiveness. The more the counselor is ready to learn to develop technical skills, the better prepared he/she is to accept the client's struggle to learn and grow.[10, 11]

With these goals in mind, supervision has become an integral part of the VRC staff functioning at BIMC. Initially, with

a small staff, supervision was in a one-to-one situation. As the size of the staff increased, group supervision became necessary. With group supervision came the realization that learning with peers facilitates the speed and, perhaps, the depth of learning. VRCs, who often feel isolated from each other, are able to share their positive experiences as well as their problems. With a structure in which to operate, the "mystery" of VR counselling and supervision can be dispelled and patient and staff needs addressed.

The patient, as described in the VSIF, is presented in group supervision. The use of the VSIF allows the group to gain comprehensive information about the patient in a concentrated manner. It allows them to be able to formulate an objective picture of the patient, as opposed to other supervisory situations in which the presenting counselor would be called on to give a patient profile based on personal experience. Certainly, before the VSIF was used, there were many complaints of lack of awareness about the patient's life and needs. With this structured form, it is possible for a counselor to consider a wide variety of areas of the patient's life.

Questions left unasked or unanswered are helpful in the supervisory situation. The staff is able to examine the degree to which the "blanks" reflect the counselor's attitude toward the patient. When a counselor gives an incomplete profile of a patient through limiting the use of the VSIF in the interview, the group is able to deal with the lack directly. They can express feelings of being deprived of information necessary to their own patient assessment. It is possible for a patient not to receive assistance because important information is deemed irrelevant by the counselor. This problem is obviated by the form's comprehensiveness.

The style in which the VSIF is presented in the supervisory session conveys the attitude or approach to the patient held by the counselor. One staff member might review the VSIF slowly, another very quickly. It is noted that a slow reading might be reflective of hesitance to begin work on problem areas. A quick reading, on the other hand, might be a glossing over of details. The VSIF, when used in supervision, becomes a projective device. It gives the group something concrete to respond to. There is no longer a need to question omitted details; rather, the exploration focuses on quality in the approach to the patient and his/her needs.

A review of the semantic differential form and the VSIF, in the supervisory session, shows that the counselor needs clarification in defining and assessing the patient. The combination of VSIF and the semantic differential are essential in the clari-

fication process. The consequence of using both instruments is the ability to deal more appropriately with the patient.

In supervision, the structuring of clinical procedures, once implemented, dissipates the counselor's resistance to learning. Initial pressure to get a task done is soon superseded by an increased concern with assessment and planning. The structuring is beneficial to the organization of responsibilities and the realization of limitations and potentialities of carrying out a professional role. The benefits of the process are not achieved, however, without group and personal struggles. The need to continually consider the group process and reflect on problems of integration, clarity and acceptance is of prime importance to group growth.

The supervisory sessions include time for group members to discuss their learning problems and reflect on changes accomplished. The counselors begin to identify instances of increased sensitivity to verbal and non-verbal interaction with patients and are better able to explore patient needs. When experiences within the counselling sessions are connected to those in the group supervisory sessions, the need for direct, open and honest communication and a conscious response to interaction is clarified.

Direct efforts are made to enhance communications within the group and to get to the underlying dynamics of behavior. Once commitment is made, there is an increased ease in presenting patients and developing specific, creative treatment plans.

Key issues in VR counselling

Following is a summary of the factors to be dealt with in the course of the counselling process. They are considered relevant to potential clinical experiences since they represent sources of influence on the client-counselor relationship.

1. Consider addiction as a disability.
2. Focus on the details of VR and the VR needs of clients as individuals.
3. Concretely define the counselling process and establish a contract. Few ex-addicts are sophisticated about one-to-one relationships.
4. Resist making assumptions about patients. The client's need to appear positive or negative may be a denial.
5. Be influenced by the needs of the patient. The patient may not want to appear in need.
6. Listen closely to the client and be in touch with the feelings expressed.

7. Confront, question, explore what the client is asking for. The ex-addict has been subjected to much questioning but little that was positively oriented.
8. Feel a sense of responsibility for the care of the patient but not to the point where it does not allow for the patient taking responsibility for him/herself. The dependency that often appears may be all the person knows so far. Drugs fulfilled many needs! There is a need for positive substitutes that are self-determined.
9. Be in touch with self and client.
10. Counsel with creativity and expand the opportunities for the client.
11. Be willing and able to make definitive statements.

VR cannot exist in an environment that does not allow for growth and change. If a patient and a counselor are discussing the degree of responsibility necessary to function as a productive member of society, the relationship must encourage behavior which allows for this goal to be met. The addict must be helped to deal with his/her problems in an atmosphere that conveys confidence and respect. These elements are especially necessary for a group which has had little respect or acceptance from the community.

The problems of the abuser in going back to work, in **any** capacity, are so large and diversified that the VRC must be receptive to individual needs and the individual means for enhancing rehabilitation.

CLINICAL PROFILES

CLINICAL PROFILES

Introduction

The Clinical Profiles section demonstrates the impact of the clinical procedures on the patients for whom problems were assessed and plans developed. Three cases are presented in depth to allow for the broadest possible insight into our approach to assessment and planning.

For those who have had experience working with ex-addicts, the content may not be entirely new. Hopefully, however, "old" learning can be reinforced and expanded through the sharing of experience with others.

For those who have not had the occasion to work with the former addict, these cases may provide a stimulus to proceed and directions to consider. Styles and means of interaction may already be developed, but through the experiences of others it is possible to gain in new areas.

For the supervisor the content of this volume represents an orientation to VR which can be implemented where appropriate. The personal and professional rewards available for the supervisor from an integrated and well-functioning team are a stimulus to further growth and development. There is a never-ending urgency to be expansive and innovative in dealing with the needs of the addict population, as well as with the staff which attempts to meet these needs.

The Clinical Profiles demonstrate that it is possible to define and implement realistic improvements in clinical services. Note should be taken, however, that improvement of old problems is often followed by the emergence of new problems.

First Clinical Profile (See page 37 for completed VSIF) *

Rationale For Selection

In our setting, where admissions are on-going, there are patients who have been in treatment for three months, are stabilized on methadone but remain unemployed. This category represents a group of patients in a crucial stage of change who may well benefit from early vocational planning. As reflected by this patient, it is possible to formulate a patient profile and to consider the way in which a counselor responds to a patient who is new in treatment.

Patient Profile

Ms. X is a 43-year-old white woman, the mother of five, separated from her husband and living with a man she describes as a "companion." The patient was admitted to the program three months ago and has been engaged only minimally in clinical activities. She claims to have become an addict many

years ago but has had no successful treatment experiences. She had many detoxifications. In addition to her drug problems, she has had three operations for colitis and has varicose veins in both legs. Ms. X has had little work experience except for several months as a chambermaid. The patient was referred to VR because she had been drug free for several months but was not showing interest in anything. Her general counselor felt that vocational activities might be helpful to Ms. X.

Plan Formulation

During the group supervisory session, after discussing the patient's self-presentation during the initial interview, group participants questioned details that had not been included on the form.

What was occurring during the session was a consideration of the use of the VSIF as a device for a clinical supervisory experience. The initial confrontation with the lack of completeness in the VSIF occupied much of the first session. Since the VSIF is a structuring device, its use brought out a concern for details and a need for clarity in presentation. Much energy was expanded in response to the completed VSIF and the initial patient interview.

Effort was then directed to developing a treatment plan. However, the group members were divergent in their perception of the patient, partly because of the details missing from the VSIF. When the details were provided by the interviewing counselor, the patient profile was expanded. A treatment plan developed by the interviewing counselor was presented.

Initial Treatment Plan Presented by VRC

1. Patient should undergo medical evaluation to determine what limitations, if any, are imposed on employment by physical condition.
2. Patient should be helped to accept these limitations and to follow through on medical advice regarding such treatment as may be prescribed.
3. Patient's general life style should be evaluated to determine what obstacles to rehabilitation exist.
4. Patient should be helped to understand these obstacles and how they may be overcome to as great an extent as possible.
5. Patient should be helped to begin structured activity so as to learn fundamentals of work-oriented behavior.
6. Patient should be encouraged, through counselling relationship, to explore areas of interest and ability so as to widen range of vocational possibilities.

7. Patient should be encouraged to undergo a vocational evaluation so as to be exposed to a variety of work tasks which may not previously have been considered.
8. Patient should be encouraged to gain awareness of sources of satisfaction and of stress as these relate to work activity as well as to life style.
9. Through combination of counselling and evaluation, patient should be helped to understand own feelings about work and to evaluate own strengths and weaknesses.
10. Patient should be encouraged to explore possibilities and to evaluate them as they relate to increasing awareness of self as worker.
11. Throughout process, patient should be helped to bridge whatever gaps exist between vocational areas and general life style, so as to increase the meaningfulness of the vocational exploration and counselling experience.

The following discussion of the treatment plan is meant to serve the purpose of sharing the discussion process (including commentary on the relevance of the steps involved) and a few of the suggested alternatives.

Discussion of Initial Treatment Plan

Initially there was an emphasis on medical evaluations and an assessment of strengths and limitations in terms of ultimate vocational capacities. Although this emphasis reflected accuracy in evaluation, it was seen at first as superseding the establishment of a positive relationship. Also reflected was a "doing to" the patient rather than helping the patient do for herself. Despite the appropriateness of the plan, its value was likely to be lost because of a lack of rationale and creativity.

The group took exception to the lack of focus on engaging the patient in a counselling relationship, as well as the seemingly minimal concern about the patient's ability to interact with the environment without the use of a drug. This conveyed a feeling of optimism about the patient who had not yet experienced failure since entering treatment.

The first step in a plan for this patient might better have explored possibilities for establishing a relationship that was supportive and sought to remove the patient from a perceived sense of communal isolation. Relationships outside of treatment are often, at this point in treatment, imperceptible in terms of nature and depth. There is, therefore, a need to develop a relationship with the patient that is focused.

For this patient, Ms. X, the eventual recommendation for the first step is that the patient be accepted by the VRC in an

effort to facilitate participation in other recommended clinic activities. The next step is that the patient's strengths and weaknesses be explored in an effort to help her perceive accurately her place in her surroundings and gain a sense of self. Ultimately the exploration is expected to expose to understanding the patient's life style and the degree to which the life style would be supportive of or contrary to vocational rehabilitation.

With a basic understanding of the patient's limitations and current life style, the counselor and patient can begin to engage in vocational exploration focused on what could be done to change the current situation. It was suggested that a structured activity might help the patient learn the fundamentals of work-oriented behavior. While this suggestion was certainly valid, the means of achieving it were missing — the suggestion was vague and undefined, lacking specificity and creativity.

What might be considered is a vocationally related activity such as a school course or a volunteer job. Both of these would provide a means of socialization and structure with a minimum of stress and physical exhaustion. In addition, either would provide an opportunity for reality testing outside of the counselling relationship.

The initial plan suggested using the counselling relationship to explore areas of interest. Here again there is little acknowledgment of the patient's involvement in her rehabilitation. The patient has a narrow perspective of her own possibilities. If, however, she can be involved in her own planning, she might be in a better position to consider alternatives. Through cooperation in planning, the patient can learn about herself and the world of work. Without cooperating in planning, the patient too often perceives **anything** as a possibility, and, because too many alternatives are confusion, **nothing** is possible.

The seventh step of the initial treatment plan fits in well with the revised plan where it did not in the initial plan. In the original plan, the recommendation that the patient undergo vocational evaluation is more than questionable. There is doubt that the patient could move from inactivity to a workshop evaluation solely through the help of counselling. Even if she could, it would be expected that her learning experience would be limited.

The remainder of the initial plan dealt with gaining satisfaction with work evaluation and understanding feelings about work. As a totality, steps seven through eleven tend to be vague and redundant and can perhaps be combined into one step. Without more specificity there is a feeling of gliding along a path of increasing self-awareness with minimum

vocational orientation. This "gliding" leaves the counselor without direction or milestones of growth for evaluation and suggests little for the patient in terms of outcome.

The discussion of the initial plan focused on these issues. While no concrete alternatives were offered at the time, the need for revision was obvious. The following revised plan was offered as an approach for this patient.

Revised Treatment Plan

1. Elicit the cooperation of the patient to engage in a counselling relationship that is structured and oriented toward achieving a realistic vocational goal. Emphasize the support possible within the relationship. Share an understanding of the continuity of relationships in other treatment situations, especially the clinic and the patient's relationship with the referring counselor.
2. Explore, with the patient, the current life style as it reflects an environment in which vocational activities can be a realistic component. This exploration would involve a clarification of personal, social, medical and vocational activities as they enhance or limit vocational development. Encourage patient to engage in this assessment as an effort to become more sensitive to her environment and to consider it as a contribution to her life.
3. If indicated, engage patient in speciality evaluations consistent with possible limitations. In this case, a comprehensive medical evaluation should be suggested to clarify for patient and counselor the extent, nature, possible treatment and limitations of her medical problems.
4. Assist patient's engagement in a structural vocational activity which will legitimize the stated vocational development goal. Provide the patient with an opportunity to learn from her own experiences and bring firsthand material to counselling. A part-time volunteer position or one course which may be academic or avocational are suggested. Encourage patient to share these changes with companion since such changes may disrupt relationship. Offer assistance in clarifying conflicts.
5. Help patient absorb developments and growth resulting from counselling experiences, thus providing a structured learning experience. At the same time, consider with the patient the legitimate next step. At this point in counselling, the patient may have gained awareness and sense of her ability to work. If so, it is appropriate to channel this awareness in a specific direction such as

an evaluation in a sheltered workshop which can provide a more comprehensive and definitive environment.

6. Work with the patient to adjust to new environment and to help in changing self-perception. Consider with patient alternatives recommended through this experience. Support levels of decision-making regarding definitive course.

These points are the basis of an initial treatment plan geared toward helping the patient begin to develop realistic vocational goals. There is no time limit to the individual steps. It is difficult to anticipate the speed with which change can take place, or to anticipate the degree of change. There should be an encouragement to recognize exigencies, but sight should not be lost of good clinical practice.

Once the mutual goal has been achieved, the plan can be updated to reflect the nature of the on-going relations as it relates to implementation of a more definitive course. The updated plan may include helping the patient arrange for schooling or prepare for work. It would be premature to develop such an up-dated plan before this preliminary exploratory course is completed.

Second Clinical Profile (See page 39 for completed VSIF)

Rationale For Selection

A significant number of individuals in the MMTP have been in treatment one year, are unemployed, but want to work. They represent a large proportion of the patients referred for vocational rehabilitation counselling. For patients who are unable to resolve their difficulties and establish a new life style within the first year of methadone maintenance, there appear to be clinical issues which may be resolved by comprehensive vocational assessment and planning.

The clinic staff often reviews the cases of patients who have been in treatment for one year to determine plans for future treatment. It is within this context that a patient who presents the patient counselor with few achievements but a desire to lead a productive life may be referred to the VRC. The motivation of the referral is to help the patient to change the current life style, to adapt to a new way of life, and to face the future more optimistically. As is demonstrated in the following discussion, the vocational area is frequently not the only one in which there are disruptions or lack of achievements. The patient, without a grasp of a meaningful life, is often found not to have made a clean transition from a former life style. Indeed, the patient may be peripherally involved in conflicting ways of life.

Patient Profile

Mr. Z is a 36-year-old black male who became addicted to heroin at age 15. He has served more than ten years in prison. Although he has a high school equivalency diploma, he has had only a few short-term jobs. His longest "square" position was two years as a shipping clerk, four years ago. Mr. Z has spent most of his life in street-oriented activities. Since entering treatment he has been a street vendor of perfumes. He is dissatisfied with this work because the income is unstable and he is afraid of being arrested for not having a vendor's license. His wife is physically disabled and confined to a wheelchair and unable to leave their hotel room without assistance. Mr. Z expresses anxiety regarding his present situation and a desire to change to one that is more conventional and socially acceptable.

Plan Formulation

When Mr. Z's case was presented to the supervisory group there were questions about his work status which had to be clarified before any plan could be developed. Could he be considered employed? The two status alternatives that became crystalized were based on his level of sophistication. Although he was sophisticated about the street and his job as an unlicensed vendor, he was naive and inexperienced about functioning in the "square" world. This dichotomy made further clarification of him as an individual necessary in order to plan a course of treatment. To see Mr. Z as inexperienced would negate his life experiences as an addict and his present job as a street salesman. To see him as experienced would be to overevaluate the degree to which his past functioning prepared him to cope in a non-drug environment. The group was divided as to a definition of the patient in these experienced-non-experienced, work-nonwork terms.

The group discussion focused on the need to address the degree to which one's life style is transferable as a learning experience for another drastically different life style. The group also expressed a need to understand the degree to which the counselor's norms and expectations influenced the evaluation of the patient. Conformity was apparently not Mr. Z's goal — nor need it be the goal of the counselling relationship. There was, however, a need to determine the degree of conformity desirable and realistic for this patient.

Seemingly, other individuals in a similar situation are unable to assess themselves, their feelings about work, and their role in life realistically. The only experiences that were at all clearly understood by the patient were related to a period of addiction. The treatment process had, after a year, not yet

been successful in effecting any significant life-style changes other than termination of drug use.

A basic clinical issue was, therefore, a consideration of the degree to which a patient can develop a personal identity and an awareness which will allow for planning. In order to accomplish this, or even to begin to address the issue, there is a need for the counselor to clarify his/her reactions and assumptions. Without this self-clarification on the part of the counselor, the patient cannot have a full range of vocational possibilities to consider. If the counselor can address the discrepancies and ambiguities as they are received, the patient can have the benefit of reality testing in a supportive situation.

In the case of Mr. Z, the use of the semantic differential was essential to accurately describe feelings and come to terms with the patient's realities and the degree to which they influence his life. Some of the words used to describe Mr. Z, by those who saw him as experienced and sophisticated, were active, strong, industrious, flexible, serious and talkative. Counselors who saw him as inexperienced and naive described him as weak, calm, staid and serious. In addition, there were questions as to his level of hesitancy and cautiousness. Further discussion led to a clarification of Mr. Z's profile as that of a person apparently in great conflict, living between two worlds, neither of which was strong enough to cause more movement than an appointment with a VRC. It was agreed that Mr. Z was ambivalent about change, that it would take a long time before he could clarify his position and legitimize his desire to change. Certainly, the degree to which he felt in crisis would have a bearing on the outcome of his treatment.

The treatment plan went through many revisions as the counselors worked on a theory that would be suitable for working with this patient. The treatment plan shown here is the last revision.

Revised Treatment Plan

1. Work with patient toward developing a trusting relationship through which the patient can be helped to feel more confident and consider the possible changes he wishes to make in his life. The relationship would provide acceptance "off the street" where structure, limits and goals can be established.
2. Consult clinic staff about the patient's physical condition and support patient in following through on recommended medical treatment. This consultation will assess the degree of liver damage present and its potential limitations for the patient.

3. Explore with patient his present life style and help him clarify and evaluate its advantages and disadvantages. The exploration should address the patient's need to increase his self-awareness and evaluate what he has learned on the street. Through such evaluation he may begin to see what he has to give up and what he may gain from changes. He will have an opportunity to make whatever decisions he can, based on more logical input than has been available to him.
4. Explore with patient his present and past work experiences. An exploration of past and present work experiences will help the patient broaden his scope of occupational information. In addition, he may come to learn what skills have been involved in his work, and to understand whether or not these skills can be related to possible vocational desires.
5. Consider, with the patient, alternative work possibilities available as a means of seeing the realities of more structured work. A part-time or temporary job might provide a meaningful experience, a reliable income and a source for further discussion.
6. If the patient is able to accomplish the preceding goal, discuss the meaning of more conventional work-oriented behavior. The discussion should be concrete and related to patient's present work. The discussion would help the patient relate his strengths and weaknesses to a more conventional work situation.

If the patient is able to achieve success in these efforts, the following **long-term goals** might be considered:

1. Explore the possibility of and the patient's feelings about further evaluation and/or training. The outcome of this exploration will ultimately determine a further course of treatment. The degree to which the patient wishes to change, with the opportunity to consider alternatives, will relate to a subsequent referral.
2. If the patient is agreeable to a further exploration of change, this might include an exploration of his current social relationships and the degree to which a major change might affect them. This exploration might include involvement in a group which would consist of individuals interested in attaining a structured work experience. It might also include a referral for vocational evaluation or direct full-time job placement. Referral or placement would depend on the patient's desire to achieve long-term goals. If more immediate steps are

indicated, referral to a job with on-going counselling contact might be suitable. If the needs are less immediate, exploration in a workshop might be appropriate.

Third Clinical Profile (See page 41 for completed VSIF)

Rationale For Selection

Job satisfaction and consideration for upgrading are integral to high quality VR. There are patients in treatment more than one year, who are working, but want a job change. These individuals have made an initial satisfactory adjustment to the Methadone Maintenance Treatment Program but want to improve their life situation, especially vocationally. In most instances the interest the patient expresses, in terms of VR, is to have an opportunity to explore alternatives to his/her current work situation. It sometimes develops, however, that the patient is asking for more than a job change and that he/she may be experiencing problems in areas of socialization and leisure time activities. The desired vocational changes are the focus of contract with the VRC.

Patient Profile

. Mr. X is a 22-year-old, well-dressed, white male who has completed the tenth grade. Mr. X became addicted at 15, but was never incarcerated. He has been on MMTP for four years and has been employed as a night elevator operator, on the same job, for three years. He had training in printing and courses in electricity in high school. Mr. X lives with his mother and four siblings. He is engaged to be married; his fiancee lives out of the city. He expresses interest in returning to school and establishing himself in a better job. Although he is responsive and eager for assistance, he is unanimated in his self-presentation.

Plan Formulation

The initial discussion of Mr. X revealed a dependent individual, living with his mother and four sisters, who was being encouraged by his fiancee and her father to improve himself vocationally. He presented no conscious acceptance of his achievements while on MMTP despite the fact that he was no longer continuing his seven-year addiction history. It is important then to help him evaluate his strengths and weaknesses as they influence his present situation and his future goals.

Exploration with VRC will make it possible to consider alternatives for employment or education that might be available for Mr. X. It is important to understand that a counselor's clarity of treatment goals and approach have a significant ef-

fect on treatment outcome for the patient who conveys ambivalence about making a change.

The patient was seen as having his addiction under control, maintaining employment and considering career alternatives. On the other hand, he was cautious in his approach — two training program attempts were not completed — and needed to be urged by others to make changes. In addition, Mr. X was considering many different changes at the same time: getting married, moving out of state to a rural area, returning to school. His approach to change reflected some elements of a generalized "breaking out", but lacked clarity of design and purpose.

As the counselors described their perceptions of the patient, insight was gained as to the need to avoid assumptions about him. Instead, counselors found that he should be encouraged to explore alternatives and that the counselling relationship should include the sharing of the need to establish priorities in order to help the patient direct himself appropriately.

Insights into this patient are relevant in different ways for other patients in a similar situation. The basic need is to develop a realistic picture that neither punishes the patient for not being someone he isn't, nor overestimates him because of his accomplishments.

Job up-grading is an anxiety provoking concept that is unfamiliar to many addicts and may generate anxiety in professionals as well. It is necessary, therefore, to develop a sensitivity to the inherent dynamics of job up-grading. What is constructive change? What personal awareness is necessary to decide on a change? What role do prestige and status play in job change? Can the capabilities of the patient be over- or underestimated by the counselor and/or the patient? With what consequences? How far can someone the counselor sees as a patient move out of the mold of "patient" without generating inappropriate judgmental elements?

Initial Plan

1. To establish a counselling contract and begin exploratory vocational counselling to help patient continue his vocational development. Begin by focusing on his likes and dislikes about jobs, his successes or failures and what he has learned from them as a basis for thinking about a future field of work. Discuss with patient his feelings about changing his life style in relation to himself, family, and future marriage. Discuss hobbies, school, history, earlier vocational interests.
2. Skill assessment. Probable vocational and aptitude testing, followed by discussion.

3. Probable referral or encouragement for patient to pursue areas where remediation may be needed in preparation for high school equivalency diploma.
4. Continued counselling to involve patient in active pursuit of possible area of training.
5. Training with continued counselling to integrate specific training experience with vocational goal. Help patient to continue to explore possibilities in rural areas.
6. Placement.

Discussion of Initial Plan

This plan indicates that the patient was seen as flexible and dependable and the counselor would take an active and directive role. The expectation was that, given the opportunity, the patient would do what was needed to be done.

The first step in the plan made many assumptions about the patient and the possibility that his past could be "lumped together". There was no flow nor progression in establishing a plan for treatment. Although the patient was seen as flexible, he was not given much room for flexibility.

There was no emphasis in the plan as to the patient's individuality, nor was there an anticipation of the anxieties he might be feeling about making a major change. It is important that he not go too far into anything without knowing what he's doing and why. Who is he? What does he need? What may be some of the obstacles he may face?

The recommended point of engagement then became one that was related specifically to this individual and the purpose of the relationship to him. Since he was perceived as having accepted much of what had been suggested to him in the past, it might be more realistic to try to help him make a decision and relate more independently. How much of the present job reflects his ability to function only in a low-level, unskilled, dependent type of job? Perhaps a change would be harmful to his present level of integration.

An additional questionable area is the primary consideration that training is the alternative, assuming he does in fact decide to make a move. There was no consideration that the alternative might be a different job at a new company or a better job with his present employer. Another possibility is that he might best stay where he is and consider other, non-vocational outlets that would satisfy other needs. Many people who work at night do so to stay disengaged from the mainstream.

Profile and Revised Treatment Plan

Since it had been ascertained that he might be experiencing anxiety and fear in relation to his desired vocational change, it

was decided that the treatment plan attempt to explore with the patient possible areas of pressure. Pressures that patient feels might be coming from external sources as well as or in addition to internal ones.

1. Establish relationship by focusing attention on patient's feelings concerning his anticipated change. What and who is pressuring him to change? What demands are coming from within; which from without? What does he really feel he wants to do?
2. Patient may be somewhat ambivalent and frightened about this type of exploration, but he will probably accept it and get involved in an assessment of his vocational needs and interests. It will then be necessary to explore and enhance the range of possibilities. The facilitating process will require support and clarification. Expansion of leisure activities may be indicated.
3. Work with general counselors through conferences and discussions in the agreed plan of treatment. This will alert everyone to patient's work with VR counselling and would support consistency of approach.
4. If some movement is acceptable, consider referral for equivalency diploma.
5 Assist patient in terms of a skill assessment and evaluation to determine range of abilities and interests. This can include reviewing reading material, want ads, visiting schools, or a workshop evaluation. .
6. Help patient to make a choice and help integrate it into his general life style.

Three-Month Follow-Up of This Patient

The patient was presented to the group again three months after the development of the treatment plan. The follow-up concentrated on the patient's status, with special emphasis on any changes that occurred. Attention was directed at the original plan in an effort to determine the accuracy of assessment and planning, the implementation and suitable revisions.

Here, we have focused on these elements by presenting the course of events over the past three months, an integration of events, an analysis of different approaches that might have been tried, and, finally, a revised plan.

Course of Events

During the three-month period the patient was seen by the VRC in five counselling sessions. The first session began to establish a relationship in which future goals could be explored and developed. It was apparent at the first session that the

patient did not have job change as an immediate goal, but rather was expressing an interest in change in general.

As the range of possibilities was introduced to him, however, his ambivalence and fear in the face of the alternative became obvious. He expressed a need to be concrete and to have direction. He began to feel pressure to make a definitive step and was not capable of exploring the sources of pressure. In addition, he could not see that if he moved in haste or without confidence in response to the pressure, he could limit his future possibilities. He did make a choice, however, and his requests were legitimate and seemingly realistic.

He was supported and encouraged in his efforts to return to school for his high school equivalency. He is at present enrolled in a program and is attending school four days a week. He is very satisfied with this step and finds a positive alliance with school and its ability to make him feel productive.

The patient is currently expressing an interest in college or trade school. The reality of either of these goals is being explored with him. The patient has also begun to explore apprenticeship programs where training is offered and is referring to vocational information sources for further clarification. He was also encouraged to attend an electronics exhibit — an area of expressed interest — at a local show. The plans in this area are vague and tenuous at this time. While the patient says he wants to explore possibilities, it is the counselor's impression that he is just looking for something in order to "answer them when they ask me what I'm doing."

Interpretation of Events

Despite the advances he seems to be making, there is concern on the counselor's part as to the patient's level of vocational identification and satisfaction. At this point the most that can be done is to point this concern out to the patient when appropriate and encourage more self-awareness and assuredness.

The patient expresses concern that he is doing nothing. Part of this concern can be alleviated by making significant vocational progress. The other part relates to feeling good about himself — and that is more difficult for him to accomplish.

An issue that remains a conflict is how much freedom of choice and independence can be encouraged for the patient without sacrificing quality. There is a constant need to legitimize the sense of progress he is feeling, as well as his need for clarification and precise direction. At the same time, there is a need to explore his range of possibilities as much as is possible. The counselor must understand the obstacle created by the patient's ambivalence.

It has also been important to maintain continuity with the clinic staff in terms of the patient's total care. The patient has expressed a desire to reduce his methadone dosage. This reduction, occurring at a time when many other major changes are imminent, will necessitate much support of and sensitivity to potential problem areas.

Alternate Approaches

The approach stimulated by the discussion of the patient refers more to establishing clarity of purpose and more concrete situations to which the patient can respond. It is apparent that too much independence and exploration is anxiety-provoking and limited in achieving a successful outcome. It is, therefore, necessary to reduce the more open discussion and exploration and focus instead on specific areas related to vocational and personal changes. Issues related to personal satisfaction may be explored through encouraging structured leisure time activities and opportunities for satisfaction. Concurrently, alternative means of vocational development should be introduced in an effort to engage the patient more completely in the consideration of further growth and development. Focus on the patient's present life style may aid him in achieving more of an identity on which to build.

1. Continue to support and encourage patient in his effort to evaluate and change his present situation. Explore his present life style, including social and vocational aspects, in an effort to enhance his positive identity.

2. Follow up his achievements in his high school course as a means of positive feedback. Use this experience as a means of reality testing and analysis for further growth and development.

3. Consider possible referral for vocational testing and to a workshop for a short skill evaluation if this is indicated. Help patient relate to positive aspects of performance that he demonstrates. Help identify them as improvements that can fit into his present life.

4. Support efforts to continue education or change jobs as evaluation, behavior and interest indicate.

PROJECT RESULTS

Value to patient

The ultimate value of the procedure is evident in the improved quality of the VR service provided to the patients.

The range of possible service to the patient was increased because the counselors benefitted from the structure and planning elements as well as encouragement and technical assistance of peers and supervisor. Through the supervisory process, group members had an opportunity to experience each new patient clinically and objectively, and thus were in a better position to explore the treating counselor's clinical procedures. The frequency and intensity of clinical presentations expanded the scope of patient contact, thereby increasing the opportunity to learn about a variety of problems and approaches.

The structuring of the interview and the systematic development of a plan established a framework for the patient-therapist interaction. This structuring is crucial in work with former addicts who frequently have difficulty in communication, often lack clarity of purpose, and express eagerness for rapid gratification. As the counselors stressed the concept of planning in the counselling sessions, the ex-addict became aware of personalized goals and responsibility, and the effort required to achieve the goals. In moving toward goal definition, the patient's trust of the VRC can be based on accomplishments.

This value of the systematization of individual patient needs can be better understood through the following points:

1. The focusing provided by the VSIF reduced the time needed for the initial assessment process. One counselor reported finding out more about a patient in one interview using the VSIF than in months of counselling sessions. The staff in our setting finds the VSIF a significant contribution. It elicits a large amount of relevant information in a concise manner.

2. Treatment planning is facilitated by integrating the material obtained. Counselors can utilize diagnostic tools to establish a realistic profile of the patient. Complexities within the counselling relationship, often missed without the opportunity to have a clear and objective perspective, were an invaluable source for realistic and creative planning. When this process can be shared with peers the communication of clinical skills improves patient care.

3. The enormity of the counselling process becomes manageable by focusing attention and directing effort. The counselors are better able to see the patient in a vocational perspective. The personal/social problems which might have consumed much of the counselor's attention are now shared with the appropriate members of the OPD team. This allows the VRC to maximize VR efforts with the patient.

APPENDICES

Appendix A

Background

In 1973, at a conference designed to consider the state of vocational rehabilitation of former drug abusers, professionals shared a wide variety of experiences. One outcome of the conference was a five-volume series entitled **State of the Art of Vocational Rehabilitation of Drug Abusers;** a second was the stimulation of the research described in the present volume. The research is, basically, a pilot demonstration of selected techniques available to enhance the provision of VR service. Specifically, the research is concerned with techniques of patient assessment and treatment planning and the supervisory process.

Although the conference served as immediate stimulus for the research, it would not have been completed without the impetus provided in a number of other ways:

1. Personal experience with VR of drug addicts.
2. The advent of methadone maintenance treatment.
3. The increase in government supported jobs for ex-addicts.
4. An increased understanding, personal and field-wide, of the need to be more specific and less subjective in the VR of addicts.
5. An increased acknowledgment, by the profession and the community, of the **problem** of VR for drug abusers.
6. An increased number of requests for guidance and guidelines in the field of VR of drug abusers.

The following "Considerations" section will discuss and connect some of these points and help to give a "why-to" background to the more "how-to" oriented section discussed earlier.

Traditional attitudes

Addiction has traditionally relied on medical treatment and the counselling support of ex-addicts. Addicts are, of course, accustomed to self-medication and treatment. They resist outside efforts of rehabilitation . . . and recidivism is high. The community has not made the problem easier; it has not been willing to accept, or re-accept, the ex-addict. Explicit aid has been even more difficult to obtain.

Methadone maintenance

Methadone maintenance treatment makes it possible for the individual to remain in treatment for extended periods of time, and be receptive to rehabilitation. Understanding the meaning

of work for the addict, and treating his/her many work-related problems, have begun to be recognized as important treatment objectives. Professionals who work in methadone programs are finding that a return to work is, for the addict in treatment, an integral part of treatment.

Conflict and coordination within treatment programs

Therapeutic communities have not, traditionally, had a vocational orientation. In therapeutic communities the emphasis is most often either on separation from the community, or on a reliance on problem-solving through therapy. In methadone maintenance programs, there is a medical approach with the fundamental goal being rehabilitation. Vocational rehabilitation is an integral component. In these, as in other rehabilitation programs, the ultimate goal is that the patient not return to a disruptive state. Instead, the patient is encouraged to achieve a more personally and socially acceptable life style.

The goals are, of course, compatible with the goals of VR. Success, to the VRC and to others concerned with more qualitative changes, extends to accomplishing a realistic level of employment in a steady job, with a steady source of income and personal income.

Appendix B

A Closer Look at Vocational Rehabilitation within a Methadone Maintenance Program

Introduction

The 1968 Amendments of the Vocational Rehabilitation Act (P.L. 90-391) expanded the criteria for eligibility to include the disadvantaged person. Under that new definition, individuals with a history of addiction became possible candidates for VR services. VR could reach out, on a national level, to a neglected part of society.

The task of defining a place for VR within addiction treatment has presented a need for continually stating, restating and clarifying the roles, goals, and potentialities of VR for the addict. The major obstacle to the provision of service lies in a conflict between a tenet basic to VR and a basic condition of the addict. The key word is **time.** The process of VR takes time . . . but addicts are almost always in a hurry. And often, staff members working with addicts are in a hurry.

In the midst of the urgency of the drug addict, the drug problem, and the treatment of the addict, VRCs are struggling to solve the problem of time — without sacrificing quality for

speed. The following points reflect that struggle on the part of VR at the Beth Israel Medical Center Methadone Maintenance Treatment Program.

1. **Methadone Maintenance Treatment: A Definition**

A methadone maintenance patient has a history of opiate addiction and is either currently on or has been on a maintenance dosage of methadone in an effort to become free from addiction through the blocking of the "high" and "craving" qualities of heroin.

Methadone maintenance is a medical approach to opiate addiction. For this reason, methadone patients have characteristically been seen as individuals for whom the use of methadone in maintenance treatment has been **the** answer. Evidence, however, has shown that methadone is not enough for many patients. For them, once the addiction has been dealt with, the pressures of daily living surface and can be handled only with extreme difficulty.

One of the most striking pressures is the problem of employability, both as a goal for patients to achieve and a concept for the community to accept. Patients and staff have a difficult time defining and then treating these occupational problems. It is equally difficult for them to deal with the community's response to accepting and employing the former addict.

In the face of these problems, Vocational Rehabilitation Counselling has become an essential element of support within the methadone maintenance treatment program.

2. **The Function of Vocational Rehabilitation Counselling**

The VR department faces eight primary responsibilities:

—to provide counselling and guidance to patients to obtain and maintain suitable employment.

—to assess patient vocational needs.

—to provide non-VR staff with training in meeting the vocational needs of the patients.

—to develop and explore relationships with community agencies for evaluation, education and training.

—to establish and broaden placement opportunities.

—to lessen the discrimination which confronts methadone patients.

—to develop vocational information and resource files.

—to evaluate and improve VR services.

3. **Training professional and non-professional staff of other disciplines in techniques of VR Counselling**

The concepts of VR are seemingly alien to people not in the profession. The need felt by the non-VR staff for immediate results has always been an obstacle to the full inclusion of VR services within a basic program. The most often heard rebuttal to offers of counselling and guidance, evaluation and exploration of vocational goals is, "But he needs a job **now.** If he had a job everything would be okay." It really would be miraculous if all he needed were a job.

The patient's daily contact is with his/her clinic counselor. It is in this relationship that he/she should begin to address his/her concern regarding confrontation with the business and industrial community. The clinic staff needs to become aware of the complexities associated with work — to become sensitive to vocational adjustment as a rehabilitation goal.

It is the responsibility of the VRC to train non-VR staff to be aware of and able to deal with the reality of the value of work. Patients often present deep-seated problems about employment. Helping patients to prepare for entry into the labor market requires attention to the psychological components of job readiness, job satisfaction and work adjustment. The training of the non-VR staff to focus on these areas so that they can help patients to delay gratification and take transitional steps is the responsibility of the VRC — and an on-going struggle.

4. **Delivery of VR services**

The delivery of VR services takes place, of course, through its counselors. Delivery is divided between direct patient care and the provision of information. The services to be delivered are a response to surveys of patient characteristics and needs, those expressed and those anticipated, as well as individualized experiences.

In the context of direct patient care, it is necessary to work through the non-VR counselors. The VRC attempts to assist in the definition of the vocational problems the patient is experiencing. Suggestions may be offered to the primary counselor for follow-up, or referral may be made to VR if the patient's problems appear complex enough. If the referral is made, the rehabilitation counselor will continue to provide counselling services to the patient until the vocational goal is achieved. Often this includes efforts directed at overcoming feelings of inadequacy and isolation. A major objective of counselling is to help the patient establish a realistic identity as an employee and to engage in vocational planning.

Efforts that are taken to communicate vocational information within each clinic include:

—the sharing of patients' clinical experiences with the staff.

—the provision of basic resource material.

—the encouragement of staff to utilize available resources.

—the holding of formal and informal discussions about patients.

—the announcement of training and employment opportunities.

—the maintenance of an on-going vocational information notebook and file.

—the maintenance of a vocational information bulletin board.

In all of these areas, attention should be given to a delivery system that maintains a personal flavor. This necessitates that the VRC should be seen as a member of the team and function as an integral part of the staff.

The VR department has been designated as the focal point for establishing rapport with the business sector, to develop jobs, to address issues of discrimination and to attack the many barriers to employment of the addict, such as bonding, licensing and certification. The complexities are in direct proportion to the business and industrial community's willingness to hire the ex-addict and the program's ability to supply qualified and reliable people.

5. **Identification and evaluation techniques**

A pilot survey reports on the difference between working and non-working Methadone Treatment Program patients.[4] The objective of the survey was to improve rehabilitation services through a better understanding of the patients' needs and interests. The survey found that approximately two-thirds of patients in treatment from one to two years were employed. Significant problems, however, in the areas of work adjustment and job satisfaction continued to exist for these patients. The most serious problems concerned job satisfaction, awareness of potential for vocational growth and development and use of leisure time. Conflicts continued in terms of changing a life style and comfortably returning to the community. The non-employed groups of patients were seen as needing a full range of vocational rehabilitation counselling.

6. **Community attitudes**

Aside from the patient's psychological readiness to start work, the business community, consciously or not, presents a myriad

of barriers to the attainment of meaningful employment and acceptance. These barriers are most often seen in terms of employment discrimination, bonding, licensing, and refusal to hire an ex-addict with a long criminal history and at present maintained on methadone. Whether the discrimination is toward the history of addiction and convictions or the methadone status itself, the destructive effects are the same.

Discrimination is also felt in facilities for leisure time activities. Most centers are unwilling to include an ex-addict. Those that do accept ex-addicts present enormous bridges for the patient to cross. It is our belief that treatment programs have the responsibility to ease this gap as a further rehabilitation goal. Patients, working out, express widespread dissatisfaction, loneliness and isolation in regard to leisure activities.

Efforts have been directed toward establishing contact with employers and employment agencies who would be agreeable to permitting a patient to present himself honestly and providing him with equal opportunities in employment. Legal means have been sought to change legislation and attack possible discriminatory experiences of patients, but returns from these efforts are slow.

Appendix C

Alcohol Treatment Program (ATP)

One member of each of the two groups described in the body of the report works in the Alcohol Treatment Program. The ATP is designed to offer comprehensive services to people residing or employed in the lower Manhattan area. It consists of three main elements: a 50-bed detoxification unit, an out-patient clinic with a patient population of 500, and a 50-bed residential halfway house.

The in-patient unit provides seven days of hospitalization and for many reflects the means of entrance into the program.

The out-patient clinic is the appropriate form of long-term treatment for most patients. It is equipped to provide a broad range of services — medical diagnosis and treatment, psychiatric consultation, social services and vocational rehabilitation counselling, recreation and occupational therapy. These services are integrated with other existing community resources. Within the out-patient clinic the patients may use Antabuse as they choose and/or may attend Alcoholics Anonymous as they choose. The clinic is available seven days a week.

The halfway house provides service through comprehensive residential treatment. The individual patient may enter the

house directly or can come on referral from the out-patient clinic. The services provided include individual and group counselling, recreation, social service and vocational rehabilitation. In this facility Antabuse is prescribed for all residents. The majority of the residents stay in the house for up to six months; however, this is voluntary.

The individual ATP patient has the benefit of services from the generalized and specialized staff members. As in the description of the MMTP, the role of the VRC in this setting is to act as a resource person and a consultant to the staff, and as a practitioner to patients whom the staff sees or who see themselves as being in need of VR services. In the halfway house the VRC assumes responsibility for general counselling as well as special vocational services.

For further reference to the functioning of the VRC in the ATP, one would look to the discussion of the MMTP, since the MMTP was the model for VR in the ATP. A special element that has been added to this program is a comprehensive pre-vocational program which exists within a day-room setting. This includes simulated work experiences in clerical tasks and in the operation of a commissary. In addition a teacher, assigned by the Board of Education, provides a five day a week high school equivalency course. These services have provided a means for engaging the more isolated and unskilled patients in activities that pave the way toward more advanced rehabilitation.

Appendix D

Drug Addiction VR Staff Participation in Project

A third group that participated in this research consisted of the VRCs who work on the Drug Addiction Service (DAS), a three-week heroin detoxification unit located in the Morris J. Bernstein Institute of Beth Israel Medical Center. The facility is primarily geared toward brief hospitalization with an emphasis on medical treatment and counselling which focuses on developing suitable plans for after-care. A typical patient stays in the hospital for eleven days, the amount of time necessary to detoxify from heroin and other substances of abuse. The goal, however, remains to try to provide a vital component of drug treatment, detoxification and the opportunity to explore alternatives. Many patients return to this facility time and time again, repeatedly failing in their rehabilitation and requiring further care.

The staffing in DAS is essentially generic in nature, with the entire team sharing in the responsibilities of patient care. The disciplines that are represented are, in addition to medicine, psychiatry, nursing, social service, occupational therapy, recreation therapy and vocational rehabilitation. All staff members have a case load and provide the full range of services, while concurrently introducing their special skills either to their patients or the patients of other staff members who may need this expertise. In this way the VRC, for example, has a case load and also develops activities and services suitable to the needs of all the patients. This may include introducing pre-vocational activities, educational programs, resources for referral, and the evaluation of individual skills and interests.

In preparation for this project, it was essential for the vocational rehabilitation staff to re-clarify the role of VR in DAS. This proved beneficial both as a stimulus and as a consolidating technique. The outgrowth of this was the development of a form similar to the VSIF, but one that reflected their particular needs and concerns for emphasis in planning. The development of the form proved to be a positive and integrating experience.

The majority of the time these counselors spend is in generic functioning, and not as VRCs. They had problems, therefore, in integrating the two and functioning as professional VRCs. However, in examining their skills in the generic capacity, problems also appeared in terms of being in touch with what the patient is saying. They were not approaching counselling as a clinical process. An attempt was made to help the counselors become more aware of what they are doing, and how they can help the patient beyond simple maintenance.

Appendix E (Pages 43-48)

1. VSIF for Methadone Program
2. VSIF for Alcohol Program
3. VSIF for Drug Addiction Service

(Enlarged copies of forms available from authors)

Appendix F (Page 49)

Semantic Differential

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BETH ISRAEL MEDICAL CENTER
METHADONE MAINTENANCE TREATMENT PROGRAM
DEPARTMENT OF VOCATIONAL REHABILITATION

VOCATIONAL STRUCTURED INTERVIEW FORM

PATIENT'S NAME ——— ADDRESS ——— TELEPHONE # ———

DATE OF BIRTH 5/10/30 AGE 36 YRS SEX ✓ MALE ✓ FEMALE

ETHNIC ✓ WHITE — BLACK — PUERTO RICAN — OTHER (SPECIFY)

LENGTH OF TIME LIVING IN NEW YORK CITY

EDUCATION
1 2 3 4 5 6 7 8 (9) 10 11 12 H.S. GRAD/EQUIVALENCY —Y —N COLLEGE: 1 2 3 4

MAJOR IN HIGH SCHOOL NONE MAJOR IN COLLEGE — TRADE SCHOOL OR TRAINING PROGRAM: COMPLETED SUBJECT — — Y — N HOW LONG ———

TRADE or PROFESSIONAL LICENSE (SPECIFY) — CURRENT UNION MEMBERSHIP — LIVING SITUATION: ROOM (HOUSE) — OWN HOME — OTHER (SPECIFY) HOTEL — APARTMENT ✓

MARITAL STATUS — M — W ✓ NM ✓ SEP — D NUMBER OF DEPENDENTS

RESIDING WITH — SPOUSE ✓ ALONE ✓ FRIEND ✓ M —F — CHILDREN — PARENTS — RELATIVES — OTHER (SPECIFY)

SOCIAL SECURITY CARD ✓Y —N # OF SIBLINGS 4 # OF CHILDREN 3

PHYSICAL LIMITATIONS: (SPECIFY & DESCRIBE) VARICOSE VEINS COLOSTOMY

SOURCE OF INCOME WELFARE AMOUNT/WK ~ IF ON WELFARE: TYPE DAB PREVIOUSLY LENGTH OF TIME

NUMBER TIMES CONVICTED = FELONY = MISDEMEANOR MONTHS SERVED = MISDEMEANOR = FELONY CURRENTLY ON ✓ PAROLE ✓ PROBATION FOR HOW MUCH LONGER CASE PENDING —Y —N NUMBER

AGE ADDICTED TO HEROIN 36 OTHER SUBSTANCES USED DAILY BEFORE MMTP — BARB — AMPH ✓ ALC — COC DATE APPLIED MMTP 9/25/73 DATE ADMITTED MMTP TREATMENT 9/25/73

EMPLOYED AT ADMISSION BIMC — Y ✓ N FREQUENCY OF PICK-UP & TIME 2X WK — DOES YOUR SPOUSE WORK ✓ Y — N IF YES, WHAT SUPERINTENDANT

USUAL LINE OF WORK NONE PRESENT STATUS (RE: WORK) — W, FULL-TIME — W, PART-TIME ✓ STUDENT ✓ NOT WORKING — HOMEMAKER

PRESENT OCCUPATION NONE DATE BEGAN WHEN WAS LAST JOB 2 YRS AGO LENGTH OF LAST JOB 2 MONTHS

HOW OBTAINED	JOB DUTIES	HOW OBTAINED	JOB DUTIES	REASON FOR LEAVING
		HUSBAND	CHAMBERMAID	WENT BACK TO HUSBAND

PLEASE RATE PRESENT OR LAST JOB (EXCELLENT ——— POOR)
YOUR SATISFACTION WITH JOB FAIR
YOUR EMPLOYER GOOD
CO-WORKER RELATIONSHIPS GOOD
WORKING CONDITIONS FAIR
PROMOTIONAL OPPORTUNITIES POOR
YOUR SUCCESS GOOD
YOUR SALARY POOR
HOW WOULD YOUR EMPLOYER RATE YOUR WORK EXC.
WHAT SKILLS WERE REQUIRED FOR JOB CLEANING
ARE THE DEMANDS REASONABLE ✓Y —N
SALARY: /HR $62/WK UNION POSITION NET —Y ✓N

POSITIONS HELD SINCE ADMISSION BIMC-MMTP (EXCEPT PRESENT JOB)

POSITION	DATES	HOW OBTAINED	REASON FOR LEAVING	SALARY
1. —				
2. —				
3. —				
4. —				
5. —				

PREVIOUS MEDICAL TREATMENT OR HOSPITALIZATION? X YES — NO
EXPLAIN COLOSTOMY

POSITIONS HELD 5 YEARS PRIOR TO ADMISSION:

POSITION	DATES	HOW OBTAINED	WHY LEFT	SALARY
AT HOWARD JOHNSON	1971	HUSBAND	WENT BACK TO N.Y.	$2.25/hr

HAVE YOU EVER HAD: JOB COUNSELING — Y ✓ N JOB TESTING — Y ✓ N
IF YES: WHERE WHEN WHAT HAPPENED

SINCE ADMISSION HAVE YOU USED ANY DRUGS OR ALCOHOL — Y ✓ N
IF YES, SPECIFY WHAT _____ FIRST 3 MONTHS ONLY — Y — N
IF YES, WERE YOU WORKING — Y — N IF YES, HOW OFTEN

ONCE ENTERING MMTP HAVE YOU IF YES, WERE YOU WORKING — Y — N
BEEN ARRESTED — Y ✓ N IF YES, WAS IT DRUG RELATED — Y — N
HOW MANY TIMES — IF NOT DRUG RELATED WHAT WAS CHARGE _____
LAST TIME _____ WERE YOU — JAILED — PROBATION — OTHER

DOES METHADONE AFFECT YOUR ABILITY TO WORK
— POSITIVELY —NEGATIVELY ✓ NOT AT ALL

WHO DO YOU ASSOCIATE WITH AT WORK DO THEY KNOW MMTP STATUS DOES EMPLOYER KNOW MMTP STATUS —Y —N

DOES PERSONNEL OFFICE KNOW MMTP STATUS WOULD YOU WANT THIS KNOWLEDGE OR LACK OF KNOWLEDGE TO BE DIFFERENT — Y — N
— Y — N IF YES, DESCRIBE _____

WHAT WOULD YOU LIKE TO BE DOING IN THREE MONTHS SOBER, WORKING
ONE YEAR HAVE CHILDREN BACK
FIVE YEARS

DOES YOUR BEING ON WELFARE DISCOURAGE YOUR GOING TO WORK — Y ✓ N
HOW:

WHAT IS THE BIGGEST PROBLEM TO OVERCOME IN OBTAINING A JOB? MY EDUCATION

WHAT HAS MADE GOING TO WORK EASIEST FOR YOU? —

WHAT DO YOU DO IN YOUR NON-WORKING HOURS? ATTEND CLINIC WITH WHOM? —

LIST THREE VOCATIONAL CHOICES IN ORDER OF PRIORITY
SEWING MACHINE OPERATOR CLERICAL CHAMBERMAID

INTERVIEWER'S COMMENTS AND OBSERVATIONS
DO YOU FEEL PATIENT IS SUITABLE FOR ✓ VOC. REHAB. COUNSELING — PLACEMENT TRAINING
— PSYCHOTHERAPY
✓ EVALUATION
— OTHER

PROGNOSIS FOR TREATMENT: FAIR

ADDITIONAL COMMENTS: CHEERFUL, OPTIMISTIC. VERY LIMITED UNDERSTANDING OF DEMANDS OF WORKING. EMPHASIZES LACK OF EDUCATION.

SIGNATURE OF VRC

BETH ISRAEL MEDICAL CENTER
METHADONE MAINTENANCE TREATMENT PROGRAM
DEPARTMENT OF VOCATIONAL REHABILITATION

VOCATIONAL STRUCTURED INTERVIEW FORM

PATIENT'S NAME _____ ADDRESS _____ TELEPHONE # _____

DATE OF BIRTH 12/25/36 AGE 36 SEX ✓ MALE — FEMALE

ETHNIC — WHITE — OTHER (SPECIFY) ✓ BLACK — PUERTO RICAN

LENGTH OF TIME LIVING IN NEW YORK CITY

EDUCATION 1 2 3 4 5 6 7 8 9 (10) 11 12 H.S. GRAD/EQUIVALENCY ✓Y —N COLLEGE: 1 2 3 4

MAJOR IN HIGH SCHOOL —

MAJOR IN COLLEGE —

TRADE SCHOOL OR TRAINING PROGRAM: COMPLETED SUBJECT — Y ✓ N
ELECTRONICS HOW LONG 3 MOS

TRADE or PROFESSIONAL LICENSE (SPECIFY) —

CURRENT UNION MEMBERSHIP —

LIVING SITUATION: ROOM (HOUSE) — OTHER (SPECIFY) HOTEL ✓ OWN HOME —

MARITAL STATUS ✓ M — W — NM — SEP — D

NUMBER OF DEPENDENTS

RESIDING WITH ✓ SPOUSE — ALONE — FRIEND — M — F — CHILDREN — PARENTS — RELATIVES — OTHER (SPECIFY)

SOCIAL SECURITY CARD ✓Y —N

OF SIBLINGS 5

OF CHILDREN 2

PHYSICAL LIMITATIONS (SPECIFY & DESCRIBE) POSS LIVER DAMAGE

SOURCE OF INCOME SPOUSE + SELL PERFUME AMOUNT/WK 250-300

IF ON WELFARE: TYPE — LENGTH OF TIME —

NUMBER TIMES CONVICTED 2 FELONY 12 MISDEMEANOR

MONTHS SERVED 30 MISDEMEANOR 18 FELONY

CURRENTLY ON — PAROLE — PROBATION

FOR HOW MUCH LONGER CASE PENDING ✓Y —N NUMBER 1

AGE ADDICTED TO HEROIN 15

OTHER SUBSTANCES USED DAILY BEFORE MMTP — BARB ✓ ALC — AMPH — COC

DATE APPLIED MMTP 1/73

DATE ADMITTED MMTP TREATMENT 1/73

EMPLOYED AT ADMISSION BIMC — Y ✓ N

FREQUENCY OF PICK-UP & TIME 5 X WK —

DOES YOUR SPOUSE WORK — Y ✓ N

IF YES, WHAT

USUAL LINE OF WORK COMMON LABORER — W, FULL-TIME — W, PART-TIME — STUDENT ✓ NOT WORKING — HOMEMAKER

PRESENT OCCUPATION	DATE BEGAN	WHEN WAS LAST JOB	LENGTH OF LAST JOB
SELLING PERFUME	—	1/72	1 YEAR

HOW OBTAINED	JOB DUTIES	HOW OBTAINED	JOB DUTIES	REASON FOR LEAVING
FRIEND	-	FRIEND	SUPERINTENDANT 3 BUILDINGS	DRUGS

PLEASE RATE ~~PRESENT~~ OR LAST JOB (EXCELLENT ——— POOR)
YOUR SATISFACTION WITH JOB FAIR
YOUR EMPLOYER GOOD
CO-WORKER RELATIONSHIPS NONE
WORKING CONDITIONS GOOD
PROMOTIONAL OPPORTUNITIES NONE
YOUR SUCCESS EXC
YOUR SALARY POOR
HOW WOULD YOUR EMPLOYER RATE YOUR WORK GOOD
WHAT SKILLS WERE REQUIRED FOR JOB PAINTING, PLUMBING, REPAIRS, OIL BURNER
ARE THE DEMANDS REASONABLE ✓Y —N
SALARY: /HR /WK UNION POSITION $65/MO + BOARD + BONUSES —Y ✓N

POSITIONS HELD SINCE ADMISSION BIMC-MMTP (EXCEPT PRESENT JOB)

POSITION	DATES	HOW OBTAINED	REASON FOR LEAVING	SALARY
1.				
2.	NONE			
3.				
4.				
5.				

PREVIOUS MEDICAL TREATMENT OR HOSPITALIZATION? ✓ YES — NO
EXPLAIN 1 HEROIN DETOX + SEVERAL ALCOHOL DETOX

POSITIONS HELD 5 YEARS PRIOR TO ADMISSION:

POSITION	DATES	HOW OBTAINED	WHY LEFT	SALARY
SUPER-3BLDGS	71-72	FRIEND	DRUGS	65/MO + BOARD
TRUCK LOADER	3'71-4'71	"	HOSPITALIZED	$120-160 WK
PORTER	3'70-1'71	"	TIRED OF IT	$50 WK + COCAINE

HAVE YOU EVER HAD: JOB COUNSELING — Y ✓ N JOB TESTING — Y ✓ N
IF YES: WHERE WHEN WHAT HAPPENED

SINCE ADMISSION HAVE YOU USED ANY DRUGS OR ALCOHOL ✓ Y — N
IF YES, SPECIFY WHAT ALCOHOL FIRST 3 MONTHS ONLY — Y ✓ N
IF YES, WERE YOU WORKING — Y ✓ N IF YES, HOW OFTEN

ONCE ENTERING MMTP HAVE YOU BEEN ARRESTED ✓ Y — N
HOW MANY TIMES 1
LAST TIME 6/73
IF YES, WERE YOU WORKING — Y ✓ N
IF YES, WAS IT DRUG RELATED ✓ Y — N
IF NOT DRUG RELATED WHAT WAS CHARGE SALE METHADONE
WERE YOU — JAILED — PROBATION ✓ OTHER PENDING

DOES METHADONE AFFECT YOUR ABILITY TO WORK
— POSITIVELY —NEGATIVELY ✓ NOT AT ALL

WHO DO YOU ASSOCIATE WITH AT WORK —
DO THEY KNOW MMTP STATUS —
DOES EMPLOYER KNOW MMTP STATUS —Y —N

DOES PERSONNEL OFFICE KNOW MMTP STATUS — Y — N
WOULD YOU WANT THIS KNOWLEDGE OR LACK OF KNOWLEDGE TO BE DIFFERENT — Y — N
IF YES, DESCRIBE ———

WHAT WOULD YOU LIKE TO BE DOING IN THREE MONTHS GET OFF STREETS
ONE YEAR GOD JOB-MANUAL WORK
FIVE YEARS "LIVING GOOD" + DETOX FROM METHADONE

DOES YOUR BEING ON WELFARE DISCOURAGE YOUR GOING TO WORK — Y ✓ N
HOW:

WHAT IS THE BIGGEST PROBLEM TO OVERCOME IN OBTAINING A JOB? NO SKILLS

WHAT HAS MADE GOING TO WORK EASIEST FOR YOU? DON'T KNOW

WHAT DO YOU DO IN YOUR NON-WORKING HOURS? "HANG OUT," TV, SPORTS WITH WHOM? FRIENDS

LIST THREE VOCATIONAL CHOICES IN ORDER OF PRIORITY
MAINTENANCE WORK COUNSELOR-YOUNG ADDICTS ———

INTERVIEWER'S COMMENTS AND OBSERVATIONS
DO YOU FEEL PATIENT IS SUITABLE FOR
✓ VOC. REHAB. COUNSELING ✓ PLACEMENT TRAINING
— PSYCHOTHERAPY
✓ EVALUATION
— OTHER

PROGNOSIS FOR TREATMENT: FAIR

ADDITIONAL COMMENTS: PT. SEEMED SINCERELY CONCERNED ABOUT LIFE STYLE. ANSWERED THOUGHTFULLY. SEEMS OVERWHELMED BY CHANGES STEADY JOB WOULD ENTAIL.

———
SIGNATURE OF VRC

BETH ISRAEL MEDICAL CENTER
METHADONE MAINTENANCE TREATMENT PROGRAM
DEPARTMENT OF VOCATIONAL REHABILITATION

VOCATIONAL STRUCTURED INTERVIEW FORM

PATIENT'S NAME ——— ADDRESS ——— TELEPHONE # ———

DATE OF BIRTH 7 12 8 15 1 22 AGE SEX ✓ MALE — FEMALE

ETHNIC ✓ WHITE — BLACK — PUERTO RICAN — OTHER (SPECIFY)

LENGTH OF TIME LIVING IN NEW YORK CITY: 22 YRS

EDUCATION
1 2 3 4 5 6 7 8 9 (10) 11 12 H.S. GRAD/EQUIVALENCY —Y —N COLLEGE: 1 2 3 4

MAJOR IN HIGH SCHOOL ELECTRICITY

MAJOR IN COLLEGE —

TRADE SCHOOL OR TRAINING PROGRAM: PAINTING
COMPLETED SUBJECT — Y ✓ N
HOW LONG 2 days

TRADE or PROFESSIONAL LICENSE (SPECIFY) NONE

CURRENT UNION MEMBERSHIP SEIU-LOCAL 32B SVC UNION

LIVING SITUATION:
ROOM (HOUSE) — OTHER (SPECIFY)
OWN HOME — HOTEL —
APARTMENT ✓

MARITAL STATUS
— M — W
✓ NM
— SEP
— D
NUMBER OF DEPENDENTS 0

RESIDING WITH
— SPOUSE — CHILDREN
— ALONE ✓ PARENTS
— FRIEND — RELATIVES
— M — F — OTHER (SPECIFY)

SOCIAL SECURITY CARD ✓Y —N
OF SIBLINGS 5
OF CHILDREN ———

PHYSICAL LIMITATIONS (SPECIFY & DESCRIBE) NONE

SOURCE OF INCOME EMPLOYMENT AMOUNT/WK $115 NET

IF ON WELFARE: NA
TYPE LENGTH OF TIME

NUMBER TIMES CONVICTED
0 FELONY
1 MISDEMEANOR

MONTHS SERVED
0 MISDEMEANOR
2 FELONY

CURRENTLY ON
— PAROLE
— PROBATION

FOR HOW MUCH LONGER
CASE PENDING —Y —N
NUMBER

AGE ADDICTED TO HEROIN 15-16

OTHER SUBSTANCES USED DAILY BEFORE MMTP
— BARB ✓ ALC
— AMPH — COC

DATE APPLIED MMTP 9/69

DATE ADMITTED MMTP TREATMENT 9/69

EMPLOYED AT ADMISSION BIMC — Y ✓ N

FREQUENCY OF PICK-UP & TIME 2 WK —

DOES YOUR SPOUSE WORK — Y — N

IF YES, WHAT

USUAL LINE OF WORK ELEVATOR OPERATOR

PRESENT STATUS (RE: WORK)
✓ W, FULL-TIME — W, PART-TIME — STUDENT — NOT WORKING — HOMEMAKER

PRESENT OCCUPATION	DATE BEGAN	WHEN WAS LAST JOB	LENGTH OF LAST JOB
ELEVATOR OPERATOR	MARCH 1970		

HOW OBTAINED	JOB DUTIES	HOW OBTAINED	JOB DUTIES	REASON FOR LEAVING
FRIEND	OPERATE ELEVATOR & SOME CLEANING			

PLEASE RATE PRESENT OR LAST JOB (EXCELLENT ——— POOR)
YOUR SATISFACTION WITH JOB POOR
YOUR EMPLOYER GOOD
CO-WORKER RELATIONSHIPS EXCELLENT
WORKING CONDITIONS EXCELLENT
PROMOTIONAL OPPORTUNITIES POOR
YOUR SUCCESS EXCELLENT
YOUR SALARY GOOD
HOW WOULD YOUR EMPLOYER RATE YOUR WORK EXCELLENT
WHAT SKILLS WERE REQUIRED FOR JOB NONE
ARE THE DEMANDS REASONABLE ✓Y —N
SALARY: /HR 115 /WK UNION POSITION NET ✓Y —N

POSITIONS HELD SINCE ADMISSION BIMC-MMTP (EXCEPT PRESENT JOB)

POSITION	DATES	HOW OBTAINED	REASON FOR LEAVING	SALARY
1. Present position is				
2. only job held since				
3. admission				
4.				
5.				

PREVIOUS MEDICAL TREATMENT OR HOSPITALIZATION? ✓ YES — NO
EXPLAIN 1968 - 9 DAYS DETOX FROM HEROIN

POSITIONS HELD 5 YEARS PRIOR TO ADMISSION:

POSITION	DATES	HOW OBTAINED	WHY LEFT	SALARY
PRESSMAN'S ASST	68-69	FRIEND	TO BE DETOXED	85/WK
ASST PRODUCE MGR (SUPERMKT)	68	FRIEND	ON DRUGS - WANTED TO STEAL	80/WK
FOOD DELIVERY (CAMP)	67	FRIEND	" " "	80/WK

HAVE YOU EVER HAD: JOB COUNSELING ✓ Y — N JOB TESTING ✓ Y — N
IF YES: WHERE NEIGHBORHOOD YOUTH CORPS WHEN 1973 WHAT HAPPENED NO ROOM IN AIR CONDITIONING SCHOOL

SINCE ADMISSION HAVE YOU USED ANY DRUGS OR ALCOHOL — Y ✓ N
IF YES, SPECIFY WHAT _____ FIRST 3 MONTHS ONLY — Y — N
IF YES, WERE YOU WORKING — Y — N IF YES, HOW OFTEN

ONCE ENTERING MMTP HAVE YOU BEEN ARRESTED — Y ✓ N
HOW MANY TIMES —
LAST TIME _____
IF YES, WERE YOU WORKING — Y — N
IF YES, WAS IT DRUG RELATED — Y — N
IF NOT DRUG RELATED WHAT WAS CHARGE _____
WERE YOU — JAILED — PROBATION — OTHER

DOES METHADONE AFFECT YOUR ABILITY TO WORK
— POSITIVELY —NEGATIVELY ✓ NOT AT ALL

WHO DO YOU ASSOCIATE WITH AT WORK NO ONE - WORK ALONE AT NIGHT
DO THEY KNOW MMTP STATUS NO
DOES EMPLOYER KNOW MMTP STATUS —Y ✓N

DOES PERSONNEL OFFICE KNOW MMTP STATUS — Y ✓ N
WOULD YOU WANT THIS KNOWLEDGE OR LACK OF KNOWLEDGE TO BE DIFFERENT — Y ✓ N
IF YES, DESCRIBE _____

WHAT WOULD YOU LIKE TO BE DOING IN THREE MONTHS GOING TO SCHOOL
ONE YEAR FINISHING SCHOOL
FIVE YEARS ESTABLISHED IN REPUTABLE JOB

DOES YOUR BEING ON WELFARE DISCOURAGE YOUR GOING TO WORK — Y — N
HOW: N/A

WHAT IS THE BIGGEST PROBLEM TO OVERCOME IN OBTAINING A JOB? QUALIFICATIONS
WHAT HAS MADE GOING TO WORK EASIEST FOR YOU? STEADY SALARY
WHAT DO YOU DO IN YOUR NON-WORKING HOURS? TV, DATE ON WEEKENDS WITH WHOM? GIRLFRIEND
LIST THREE VOCATIONAL CHOICES IN ORDER OF PRIORITY
ELECTRICITY PLUMBING CARPENTRY

INTERVIEWER'S COMMENTS AND OBSERVATIONS
DO YOU FEEL PATIENT IS SUITABLE FOR
✓ VOC. REHAB. COUNSELING — PLACEMENT
— PSYCHOTHERAPY ✓ TRAINING
— EVALUATION
— OTHER

PROGNOSIS FOR TREATMENT: VERY GOOD
ADDITIONAL COMMENTS: PT. PRESENTS NEAT APPEARANCE. ANSWERS QUESTIONS & VOLUNTEERS INFORMATION WILLINGLY. PRESENTS HIMSELF IN FLAT-INAMINATED FASHION.

SIGNATURE OF VRC

VOCATIONAL
STRUCTURED
INTERVIEW FORMS

BETH ISRAEL MEDICAL CENTER
METHADONE MAINTENANCE TREATMENT PROGRAM
DEPARTMENT OF VOCATIONAL REHABILITATION

VOCATIONAL STRUCTURED INTERVIEW FORM

PATIENT'S NAME ADDRESS TELEPHONE #

DATE OF BIRTH / / AGE SEX — MALE — FEMALE

ETHNIC —— WHITE —— BLACK —— PUERTO RICAN —— OTHER (SPECIFY)

LENGTH OF TIME LIVING IN NEW YORK CITY

EDUCATION
1 2 3 4 5 6 7 8 9 10 11 12 H.S. GRAD/EQUIVALENCY —Y —N COLLEGE: 1 2 3 4

MAJOR IN HIGH SCHOOL MAJOR IN COLLEGE TRADE SCHOOL OR TRAINING PROGRAM: COMPLETED SUBJECT — Y — N HOW LONG ——

TRADE or PROFESSIONAL LICENSE (SPECIFY) CURRENT UNION MEMBERSHIP LIVING SITUATION: ROOM (HOUSE) — OWN HOME — OTHER (SPECIFY) HOTEL —

MARITAL STATUS — M — W — NM — SEP — D NUMBER OF DEPENDENTS

RESIDING WITH — SPOUSE — ALONE — FRIEND — M —F — CHILDREN — PARENTS — RELATIVES — OTHER (SPECIFY)

SOCIAL SECURITY CARD —Y —N # OF SIBLINGS ____ # OF CHILDREN ____

PHYSICAL LIMITATIONS (SPECIFY & DESCRIBE)

SOURCE OF INCOME AMOUNT/WK IF ON WELFARE: TYPE LENGTH OF TIME

NUMBER TIMES CONVICTED — FELONY — MISDEMEANOR MONTHS SERVED — MISDEMEANOR — FELONY CURRENTLY ON — PAROLE — PROBATION FOR HOW MUCH LONGER CASE PENDING —Y —N NUMBER

AGE ADDICTED TO HEROIN OTHER SUBSTANCES USED DAILY BEFORE MMTP — BARB — AMPH — ALC — COC DATE APPLIED MMTP DATE ADMITTED MMTP TREATMENT

EMPLOYED AT ADMISSION BIMC — Y — N FREQUENCY OF PICK-UP & TIME — WK — DOES YOUR SPOUSE WORK — Y — N IF YES, WHAT

USUAL LINE OF WORK PRESENT STATUS (RE: WORK) — W, FULL-TIME — W, PART-TIME — STUDENT — NOT WORKING — HOMEMAKER

PRESENT OCCUPATION DATE BEGAN WHEN WAS LAST JOB LENGTH OF LAST JOB

HOW OBTAINED JOB DUTIES HOW OBTAINED JOB DUTIES REASON FOR LEAVING

PLEASE RATE PRESENT OR LAST JOB (EXCELLENT ——— POOR)
YOUR SATISFACTION WITH JOB ——
YOUR EMPLOYER ——
CO-WORKER RELATIONSHIPS ——
WORKING CONDITIONS ——
PROMOTIONAL OPPORTUNITIES ——
YOUR SUCCESS ——
YOUR SALARY ——
HOW WOULD YOUR EMPLOYER RATE YOUR WORK ——
WHAT SKILLS WERE REQUIRED FOR JOB

ARE THE DEMANDS REASONABLE — Y — N
SALARY: /HR /WK UNION POSITION — Y — N

POSITIONS HELD SINCE ADMISSION BIMC-MMTP (EXCEPT PRESENT JOB)

POSITION	DATES	HOW OBTAINED	REASON FOR LEAVING	SALARY
1.				
2.				
3.				
4.				
5.				

PREVIOUS MEDICAL TREATMENT OR HOSPITALIZATION? —— YES —— NO
EXPLAIN

POSITIONS HELD 5 YEARS PRIOR TO ADMISSION:

POSITION	DATES	HOW OBTAINED	WHY LEFT	SALARY

HAVE YOU EVER HAD: JOB COUNSELING — Y — N JOB TESTING — Y — N
IF YES: WHERE WHEN WHAT HAPPENED

SINCE ADMISSION HAVE YOU USED ANY DRUGS OR ALCOHOL — Y — N
IF YES, SPECIFY WHAT _____ FIRST 3 MONTHS ONLY — Y — N
IF YES, WERE YOU WORKING — Y — N IF YES, HOW OFTEN

ONCE ENTERING MMTP HAVE YOU IF YES, WERE YOU WORKING — Y — N
BEEN ARRESTED — Y — N IF YES, WAS IT DRUG RELATED — Y — N
HOW MANY TIMES —— IF NOT DRUG RELATED WHAT WAS CHARGE _____
LAST TIME _____ WERE YOU —— JAILED —— PROBATION —— OTHER

DOES METHADONE AFFECT YOUR ABILITY TO WORK
— POSITIVELY —NEGATIVELY — NOT AT ALL

WHO DO YOU ASSOCIATE WITH AT WORK DO THEY KNOW MMTP STATUS DOES EMPLOYER KNOW MMTP STATUS —Y —N
AT NIGHT

DOES PERSONNEL OFFICE KNOW MMTP STATUS WOULD YOU WANT THIS KNOWLEDGE OR LACK OF KNOWLEDGE TO BE DIFFERENT — Y — N
—— Y —— N IF YES, DESCRIBE _____

WHAT WOULD YOU LIKE TO BE DOING IN THREE MONTHS
ONE YEAR
FIVE YEARS

DOES YOUR BEING ON WELFARE DISCOURAGE YOUR GOING TO WORK —— Y —— N
HOW:

WHAT IS THE BIGGEST PROBLEM TO OVERCOME IN OBTAINING A JOB?

WHAT HAS MADE GOING TO WORK EASIEST FOR YOU?

WHAT DO YOU DO IN YOUR NON-WORKING HOURS? WITH WHOM?

LIST THREE VOCATIONAL CHOICES IN ORDER OF PRIORITY

_____ _____ _____

INTERVIEWER'S COMMENTS AND OBSERVATIONS
DO YOU FEEL PATIENT IS SUITABLE FOR — VOC. REHAB. COUNSELING — PLACEMENT
— PSYCHOTHERAPY — TRAINING
— EVALUATION — OTHER

PROGNOSIS FOR TREATMENT:

ADDITIONAL COMMENTS:

_____
SIGNATURE OF VRC

BETH ISRAEL MEDICAL CENTER
ALCOHOL TREATMENT PROGRAM
DEPARTMENT OF VOCATIONAL REHABILITATION

VOCATIONAL STRUCTURED INTERVIEW FORM

PATIENT'S NAME ADDRESS TELEPHONE #

DATE OF BIRTH / / AGE SEX — MALE — FEMALE

LENGTH OF TIME LIVING IN NEW YORK CITY

ETHNIC
— WHITE — OTHER (SPECIFY)
— BLACK
— PUERTO RICAN

EDUCATION
1 2 3 4 5 6 7 8 9 10 11 12 H.S. GRAD/EQUIVALENCY —Y —N COLLEGE: 1 2 3 4

MAJOR IN HIGH SCHOOL MAJOR IN COLLEGE TRADE SCHOOL OR TRAINING PROGRAM: COMPLETED SUBJECT — Y — N HOW LONG —

TRADE or PROFESSIONAL LICENSE (SPECIFY) CURRENT UNION MEMBERSHIP LIVING SITUATION: ROOM (HOUSE) — OTHER (SPECIFY) OWN HOME — HOTEL —

MARITAL STATUS
— M — W
— NM
— SEP NUMBER OF
— D DEPENDENTS

RESIDING WITH
— SPOUSE — CHILDREN
— ALONE — PARENTS
— FRIEND — RELATIVES
— M —F — OTHER (SPECIFY)

SOCIAL SECURITY CARD —Y —N
OF SIBLINGS
OF CHILDREN

PHYSICAL LIMITATIONS, (SPECIFY & DESCRIBE)

SOURCE OF INCOME AMOUNT/WK IF ON WELFARE: TYPE LENGTH OF TIME

NUMBER TIMES CONVICTED — FELONY — MISDEMEANOR

MONTHS SERVED — MISDEMEANOR — FELONY

CURRENTLY ON — PAROLE — PROBATION

FOR HOW MUCH LONGER

CASE PENDING —Y —N
NUMBER

AGE ADDICTED TO ALCOHOL

OTHER SUBSTANCES USED DAILY BEFORE ATP
— BARB — ALC
— AMPH — COC

DATE APPLIED ATP

DATE ADMITTED ATP TREATMENT

EMPLOYED AT ADMISSION BIMC — Y — N

FREQUENCY OF PICK-UP & TIME — WK —

DOES YOUR SPOUSE WORK — Y — N

IF YES, WHAT

USUAL LINE OF WORK PRESENT STATUS (RE: WORK) — W, FULL-TIME — W, PART-TIME — STUDENT — NOT WORKING — HOMEMAKER

PRESENT OCCUPATION DATE BEGAN WHEN WAS LAST JOB LENGTH OF LAST JOB

HOW OBTAINED JOB DUTIES HOW OBTAINED JOB DUTIES REASON FOR LEAVING

PLEASE RATE PRESENT OR LAST JOB (EXCELLENT ——— POOR)
YOUR SATISFACTION WITH JOB ——
YOUR EMPLOYER ——
CO-WORKER RELATIONSHIPS ——
WORKING CONDITIONS ——
PROMOTIONAL OPPORTUNITIES ——
YOUR SUCCESS ——
YOUR SALARY ——
HOW WOULD YOUR EMPLOYER RATE YOUR WORK ——
WHAT SKILLS WERE REQUIRED FOR JOB

ARE THE DEMANDS REASONABLE —Y —N
SALARY: /HR /WK UNION POSITION —Y —N

POSITIONS HELD SINCE ADMISSION BIMC-ATP (EXCEPT PRESENT JOB)

POSITION	DATES	HOW OBTAINED	REASON FOR LEAVING	SALARY
1.				
2.				
3.				
4.				
5.				

ARE YOU ON ANTABUSE? — Y — N
IF YES, SINCE WHEN _____

EVER BEFORE? — Y — N WHEN —

PREVIOUS MEDICAL TREATMENT OR HOSPITALIZATION? — Y — N
EXPLAIN:

POSITIONS HELD 5 YEARS PRIOR TO ADMISSION

POSITION	DATES	HOW OBTAINED	WHY LEFT	SALARY

HAVE YOU EVER HAD: JOB COUNSELING — Y — N JOB TESTING — Y — N
IF YES: WHERE WHEN WHAT HAPPENED

SINCE ADMISSION HAVE YOU USED ANY DRUGS OR ALCOHOL — Y — N
IF YES, SPECIFY WHAT _____ FIRST 3 MONTHS ONLY — Y — N
IF YES, WERE YOU WORKING — Y — N IF YES, HOW OFTEN

ONCE ENTERING ATP HAVE YOU BEEN ARRESTED — Y — N
HOW MANY TIMES ____
LAST TIME _____

IF YES, WERE YOU WORKING — Y — N
IF YES, WAS IT ALCOHOL RELATED — Y — N
IF NOT ALCOHOL RELATED WHAT WAS CHARGE _____
WERE YOU ____ JAILED ____ PROBATION ____ OTHER

DOES ATP AFFECT YOUR ABILITY TO WORK
____ Y ____ N

DOES ANTABUSE AFFECT YOUR ABILITY TO WORK
— POSITIVELY —NEGATIVELY — NOT AT ALL

WHO DO YOU ASSOCIATE WITH AT WORK DO THEY KNOW ATP STATUS DOES EMPLOYER KNOW ATP STATUS —Y —N

DOES PERSONNEL OFFICE KNOW ATP STATUS
____ Y ____ N

WOULD YOU WANT THIS KNOWLEDGE OR LACK OF KNOWLEDGE TO BE DIFFERENT — Y — N
IF YES, DESCRIBE _____

WHAT WOULD YOU LIKE TO BE DOING IN THREE MONTHS _____
ONE YEAR _____
FIVE YEARS _____

DOES YOUR BEING ON WELFARE DISCOURAGE YOUR GOING TO WORK ____ Y ____ N
HOW:

WHAT IS THE BIGGEST PROBLEM TO OVERCOME IN OBTAINING A JOB?

WHAT HAS MADE GOING TO WORK EASIEST FOR YOU?

WHAT DO YOU DO IN YOUR NON-WORKING HOURS? WITH WHOM?

LIST THREE VOCATIONAL CHOICES IN ORDER OF PRIORITY

_____ _____ _____

INTERVIEWER'S COMMENTS AND OBSERVATIONS
DO YOU FEEL PATIENT IS SUITABLE FOR

— VOC. REHAB. COUNSELING — PLACEMENT
— PSYCHOTHERAPY TRAINING
— EVALUATION
— OTHER

PROGNOSIS FOR TREATMENT:

ADDITIONAL COMMENTS:

_____
SIGNATURE OF VRC

BETH ISRAEL MEDICAL CENTER
DRUG ADDICTION SERVICE
DEPARTMENT OF VOCATIONAL REHABILITATION

VOCATIONAL STRUCTURED INTERVIEW FORM

PATIENT'S NAME ADDRESS TELEPHONE #

PERSONAL-SOCIAL

NAME: _____ DATE OF BIRTH: _____ AGE: _____

PLACE OF RESIDENCE _____ SEX: _____ MARITAL STATUS: _____

APARTMENT RESIDING WITH: TIME LIVING IN NEW YORK _____
ROOM (HOTEL) _____ WHERE LIVING BEFORE NEW YORK:
HOME
OTHER (SPECIFY) HOW LONG THERE _____ PLACE OF BIRTH _____

IF ANY CHILDREN, WHO CARES FOR THEM _____ HAVE YOU A SOCIAL SECURITY CARD?
ANY OTHER FAMILY MEMBERS DRUG ABUSERS? — Y — N — Y — N
WHO _____ SUBSTANCE(S) _____ ANY PHYSICAL LIMITATIONS:

PRESENT SOURCE OF INCOME _____ DOES SPOUSE WORK? — Y — N
AMOUNT WEEKLY _____ IF YES, OCCUPATION _____ SALARY _____

EDUCATION:

COLLEGE (IF ANY)
LAST GRADE SCHOOL DIPLOMA OR DEG — Y — N SCHOOL:
DATES:
MAJOR:

VOCATIONAL TRAINING:
SCHOOL: MAJOR COURSE: DATES ATTENDED:
DID YOU FINISH? — Y — N _____ to _____

MILITARY

BRANCH DATES: WHERE STATIONED:
TYPE OF DISCHARGE: DUTIES WHEN IN SERVICE:
TRAINING WHILE IN SERVICE:

ADDITIONAL HISTORY
AGE FIRST USED DRUGS _____ WHAT DRUG(S) _____ OTHER DRUGS USED DAILY*
AGE FIRST ADDICTED (HEROIN) _____ _____

NUMBER OF HEROIN DETOXIFICATIONS: _____
MEANS OF SUPPORTING HABIT:

DRUG FREE PERIODS: (INDICATE WHETHER ON MMTP, RESIDENTIAL, 9-5 PROGRAM)

_____ _____ _____
_____ _____ _____

IF ON MMTP CURRENTLY:
NO. OF DETOXES OTHER SUBSTANCES _____ WHAT SUBSTANCE _____
WORKING — Y — N FULL TIME — PART TIME — HOMEMAKER — Y — N
ARE YOU BEING DETOXED FROM MMTP — Y — N IF YES, REASONS

PREVIOUS THERAPEUTIC COMMUNITY OR 9-5 PROGRAM (ADDITIONAL SPACE IF MORE THAN 1)

DATES: _____ _____ _____
PROGRAM _____ _____ _____
WHY LEFT: _____ _____ _____

CRIMINAL HISTORY:

NUMBER TIMES CONVICTED	MONTHS SERVED	CURRENTLY ON
___ FELONY	___ FELONY	___ PROBATION
___ MISDEMEANOR	___ MISDEMEANOR	___ PAROLE

EMPLOYMENT HISTORY

PREVIOUS JOBS HELD: (LAST 5 YEARS)

POSITION	DATES	HOW OBTAINED	WHY LEFT	SALARY

PRESENT JOB (OR LAST)	HOURS/WK	DATE BEGUN	HOW OBTAINED	SALARY

RATE: PRESENT JOB (EXCELLENT — POOR)

YOUR SATISFACTION WITH JOB _____

YOUR EMPLOYER _____

CO-WORKER RELATIONSHIPS _____

WORKING CONDITIONS _____

PROMOTION OPPORTUNITIES _____

YOUR SUCCESS _____

YOUR SALARY _____

HOW WOULD YOUR EMPLOYER RATE YOUR WORK _____

ADDITIONAL COMMENTS:

WHAT IS THE BIGGEST PROBLEM YOU NEED TO OVERCOME TO GET A JOB?

WHEN YOU'VE WORKED, WHAT HAS MADE GETTING A JOB EASIEST?

WHAT DO YOU DO IN YOUR NON-WORKING HOURS? WITH WHOM?

WHAT WOULD YOU LIKE THINGS TO BE LIKE IN 3 MONTHS?

WHAT WOULD YOU LIKE THINGS TO BE LIKE IN 6 MONTHS?

INDICATE 3 VOCATIONAL CHOICES IN ORDER OF PREFERENCE

_____ _____ _____

INTERVIEWER'S COMMENTS:

RECOMMENDATIONS:

_____
SIGNATURE OF VRC

SEMANTIC DIFFERENTIAL

"THIS CLIENT"

Active:	____:	____:	____:	____:	____:	____:	____:	Inactive
Hard:	____:	____:	____:	____:	____:	____:	____:	Soft
Naive:	____:	____:	____:	____:	____:	____:	____:	Sophisticated
Slow:	____:	____:	____:	____:	____:	____:	____:	Fast
Strong:	____:	____:	____:	____:	____:	____:	____:	Weak
Experienced:	____:	____:	____:	____:	____:	____:	____:	Inexperienced
Calm:	____:	____:	____:	____:	____:	____:	____:	Excitable
Staid:	____:	____:	____:	____:	____:	____:	____:	Flexible
Frivolous:	____:	____:	____:	____:	____:	____:	____:	Serious
Reticent:	____:	____:	____:	____:	____:	____:	____:	Talkative
Hesitant:	____:	____:	____:	____:	____:	____:	____:	Sure
Formal:	____:	____:	____:	____:	____:	____:	____:	Casual
Industrious:	____:	____:	____:	____:	____:	____:	____:	Lazy
Dull:	____:	____:	____:	____:	____:	____:	____:	Sharp
Dependable:	____:	____:	____:	____:	____:	____:	____:	Capricious
Cautious:	____:	____:	____:	____:	____:	____:	____:	Daring
Skilled:	____:	____:	____:	____:	____:	____:	____:	Unskilled
Willful:	____:	____:	____:	____:	____:	____:	____:	Compliant

COMMENTS

The Bernstein Institute of Beth Israel Medical Center has played a central role in the treatment of drug addiction for the past 15 years. It is the largest non-governmental hospital for treatment of addictive diseases. It currently provides a treatment approach that includes a heroin detoxification unit, an inpatient medical treatment unit for the addict, and a comprehensive MMTP program. It also has extensive services for treatment of alcoholism. There have been, since 1961, over 100,000 admissions to the heroin detoxification unit alone.

Our focus has been on the patient as an individual who is in need of a full range of opportunities in order to achieve restoration to as satisfying a life style as possible. This includes medical treatment, counselling and social services under medical supervision, and a wide range of vocational rehabilitation counseling activities. Unless the individual has the opportunity to rejoin the community with dignity, our treatment goals have not been met. It is here that vocational rehabilitation counselling is crucial in addressing the quality of life in the realm of meaningful employment.

This volume represents an important step in bringing these services closer to the individual patient in need, and to those responsible for providing services.

Harvey Gollance, M.D.
Director
Morris J. Bernstein Institute
Beth Israel Medical Center

In our society, unless an individual patient is provided with the opportunity to work, rehabilitation has been an incomplete process. We can talk about support and restoration but without the substance a meaningful job can provide, the individual remains dependently in need. The services that work to make this quality of life possible are becoming an integral part of treatment in the Beth Israel Medical Center Alcohol Treatment Program. It is our goal to provide a full range of interrelated vocational rehabilitation counselling services in order to meet individual patient needs.

The individualized approach described in this volume is an essential component in establishing a workable model for prescriptive treatment planning. I find the work described so creative and directly relevant to the treatment needs of our patients that I visualize such an approach becoming the foundation of our treatment of the individual dependent on alcohol.

Robert A. Senescu, M.D.
Director, Department of Psychiatry,
Beth Israel Medical Center

Professor of Clinical Psychiatry,
Mount Sinai School of Medicine of the
City University of New York

Vocational rehabilitation counselling is an integral part of the Methadone Maintenance Treatment Program at Beth Israel Medical Center. It is recognized that unless individuals in treatment are afforded the opportunity to explore their potential for placement in the labor market, we are neglecting a vital component of rehabilitation.

The material in this volume not only highlights the components of comprehensive vocational rehabilitation counselling but provides a workable model that may well be adapted to many treatment modalities. It has been my privilege to assist in the development of this publication.

Harold L. Trigg, M.D.
Associate Director,
Morris J. Bernstein Institute
Chief, Methadone Maintenance Treatment Program
Chief, Drug Addiction Service
Associate Professor of Clinical Psychiatry
Mount Sinai School of Medicine of the City University of New York

Vocational Rehabilitation counselors have been influenced by the major conceptual models of mental health work. These have included the psychotherapeutic model, which has emphasized the subjective, private nature of the activity, and the advocacy model, which has emphasized rapid solutions for quite complex problems. Neither of these extreme models provides a basis for sound vocational rehabilitation. This volume describes a project in which vocational rehabilitation counselors successfully applied new techniques which appear to be increasingly attractive and productive. Among the techniques were use of a structured interview, written treatment plans, emphasis on objective, attainable goals, and group supervision. Traditionalists might say this makes for a mechanical approach, and activists might say this is an inhibiting, plodding approach, but it appears to have led to more competent work by the counselors.

Henry Pinsker, M.D.
Associate Director, Department of Psychiatry,
Beth Israel Medical Center
Associate Clinical Professor of Psychiatry,
Mount Sinai School of Medicine of the
City University of New York

VOCATIONAL REHABILITATION OF THE DRUG ABUSER

Editorial Seminar

March 28-30, 1973
Mills College, Oakland, California

Advisory Council

DAVID SMITH, M.D., Chairman
Medical Director
Haight-Ashbury Free Medical Clinic
1698 Haight St.
San Francisco, California 94117

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Dr. LOUIS NAU

Mr. ROBERT A. BATTEN, JR.

WENDELL LIPSCOMB, M.D., M.P.H.

SCHEDULE

WEDNESDAY, MARCH 28

7:45-8:30 AM Registration continued (Rothwell College Center Faculty Room)

Breakfast (all meals will be in the Rothwell College Center Tea Room)

9:00 Introduction, Orientation (Rothwell College Center Faculty Room)

Herbert H. Leibowitz, Research & Demonstration Specialist Social & Rehabilitation Services, DHEW

Philip Schafer, Regional Commissioner, Social and Rehabilitation Services, DHEW

9:30 "Perspectives of Vocational Rehabilitation of the Drug Abuser"

David E. Smith, Medical Director
Haight Ashbury Free Medical Clinic

Fred Kelly, Staff Advisor, Community Planning Office of Deputy Director of Priority Program

Gregory March, Program Analyst
Rehabilitation Services Administration, SRS

Thomas Cahill, Project Coordinator
University of Miami Center for Urban Studies

Sol Silverman, Commissioner
National Commission on Marijuana & Drug Abuse

Maryann Urban, Program Director
National Commission on Marijuana & Drug Abuse

Impromptu Panel Responding:

Gerry DeAngelis, Treatment, Rehabilitation & Training Consultant, Vitam Center, Inc.

Wendell Lipscomb, Executive Director
Source, Inc.: Studies of Urban Research & Community Education

Robert Campos, Director of the Methadone Withdrawal Project Addiction Research Laboratory, Palo Alto

Irving Lucoff, Director, Addiction Research & Treatment Corporation Evaluation Team, Columbia University

Arlene Lissner, Associate Director of Program Development and Training, Illinois State Drug Abuse Program

12:30 Lunch (Tea Room)

1:30 PM	"A Theoretical Exploration" (Faculty Room) Dr. Donald E. Super, Director of Division & Chairman of the Department of Psychology, Columbia University Panel Responses: Sanford J. Feinglass, Director Institute for Social Concerns Irving F. Lukoff, Director, Addiction Research & Treatment Corporation Evaluation Team, Columbia University Charlotte Taylor, Director of Training, Division for Research & Training in Rehabilitation, University of Southern California David Franklin, School of Social Welfare, University of Southern California
3:30-5:00	Group Workshops (Lucie Stern Hall)
6:00	Social Hour (Living Room of Mary Morse Hall)
7:00	Dinner (Tea Room)
8:30	Haight Ashbury Youth Projects, Inc. Presentation of Program (Faculty Room) David Smith, Medical Director Haight Ashbury Free Medical Clinic Stuart Loomis, Director of the Psychological Services Section Haight Ashbury Free Medical Clinic Leona Jacobs-White, Director, Social Rehabilitation Section "Crackerjack," Haight Ashbury Free Medical Clinic

THURSDAY, MARCH 29

7:45-8:30 AM	Breakfast (Tea Room)
9:00	"Vocational Rehabilitation of the Drug Abuser—In Practice" Panel Presentation Regional Overview of Vocational Rehabilitation Practices (Faculty Room) Michael Gold, Project Director Jewish Employment Vocational Service, Philadelphia Jim Cosse, Research Assistant Department of Psychology, Columbia University Arlene Lissner, Associate Director of Program Development & Training, Illinois State Drug Abuse Program Edward Scott, Clinical Director Oregon State Mental Health Division

William Fletcher, Program Supervisor
Florida Department of Vocational Rehabilitation

G. G. DeAngelis, Moderator

11:15-12:15 Group Workshops (Lucie Stern Hall)

12:30 Lunch (Tea Room)

1:30 Group Workshops continue

3:30 "Defining the Rehabilitation Goal" (Faculty Room)

Thomas Cahill, Project Coordinator
University of Miami Center for Urban Studies

Joseph Carano, Acting Director of Training
Connecticut Division of Vocational Rehabilitation

Henry Kavkewitz, Professor of Psychology & Education
Department of Psychology, Columbia University

Eileen Wolkstein, Chief, Vocational Rehabilitation
Beth Israel Medical Center, New York

Howard Berger, Director of Vocational Rehabilitation
Operations, New York Office of Vocational Rehabilitation

Philip Schafer, Moderator
Regional Commissioner, SRS, Region IX

6:00 Hospitality Hour (Living Room of Mary Morse Hall)

7:00 Dinner (Tea Room)

8:30 PM Providing Service
Ex-addicts and program directors present their views

Richard Montes, Job Developer
Boyle Heights Center, Los Angeles

Franklin Jackson, Former Aide
Vera, Inc., New York

Jean Brinkley, Administrative Aide
Narcotic Educational League, Oakland

Armando Mendoza, Institute for Social Concerns

Jim Cosse, Director, Treatment Program

Jack Feinglass, Moderator

FRIDAY, MARCH 30

7:45-8:30 AM Breakfast (Tea Room)

9:00 "The Job at the End of the Rainbow" (Faculty Room)

Labor, Management and Vocational Rehabilitation Panel:

Robert S. Graham, Medical Director
Equitable Life Assurance of US

William Gregor, AFL-CIO Local Union #2869
United Steelworkers of America, Fontana, Ca.

I. Ira Goldenberg, Associate Professor of Clinical Psychology & Public Practice, Harvard University

David N. Nurco, Research Scientist
Maryland Department of Mental Hygiene

Richard Atkins, Esquire, Moderator

11:00 AM — Group Workshops in Summary (Lucie Stern Hall)

12:30 — Lunch (Tea Room)

1:30 — "Challenges of the Vocational Rehabilitation of the Drug Abuser"

Conclusions and Implications for the Future (Faculty Room)

Eileen Wolkstein, Chief, Vocational Rehabilitation
Beth Israel Medical Center, New York

Thomas Cahill, Project Coordinator
University of Miami Center for Urban Studies

Louis Nau, Special Assistant to the Commissioner
Rehabilitation Services Administration

Roger Myers, Moderator

Closing Statement:

Wade Coleman, Special Assistant to the Secretary for Drug Abuse Prevention, Washington, D.C.

RICHARD ATKINS, Esquire	Suite 1616 One East Penn Square Juniper & Market Philadelphia, Penn. 19107
FREDERICK BECKNER	Special Assistant for Program Planning & Coordination Dept. of Health, Education & Welfare Public Health Service National Institute of Mental Health 5600 Fishers Lane Rockville, Md. 20852
HOWARD BERGER	Director, Vocational Rehabilitation Operations Office of Vocational Rehabilitation New York State Education Department 99 Washington Ave. Albany, New York 12210
BART BILLINGS	Rehabilitation Counselor State Department of Rehabilitation 2240 Professional Drive Santa Rosa, Ca. 95401
BILL BRICKER	Rehabilitation Counselor Haight Ashbury Free Medical Clinic Psychological Services 409 Clayton St. San Francisco, Ca. 94117
BRUCE BROWN	Research & Demonstration Grants Coordinator Human Relations Agency Department of Rehabilitation 714 "P" Street Sacramento, Ca. 95814
THOMAS CAHILL	Project Coordinator NIMH-National Training Center University of Miami Center for Urban Studies PO Box 8002 Coral Gables, Flo. 33124
ROBERT CAMPOS	Director of the Methadone Withdrawal Project Addiction Research Laboratory 800 Welch Road, Room 363 Palo Alto, Ca. 94304

JOSEPH CARANO	Acting Director of Training Division of Vocational Rehabilitation Bureau of Community & Institutional Services State of Connecticut 600 Asylum Avenue Hartford, Conn. 06105
JOHN CHAMBLEY	Director, Rehabilitation Counseling Program Department of Education San Diego State College 5402 College San Diego, Ca. 92115
EDWARD CHAVEZ	Probation & Parole Officer II State Department of Corrections Drug Screening 510 2nd St., N.W. Albuquerque, New Mexico 87101
MICHAEL CHEMODUROW	Grant Management Specialist Vocational Rehabilitation Services 1501 McKinney Boise, Idaho 83704
WADE COLEMAN	Special Assistant to the Secretary for Drug Abuse Prevention Department of Health, Education, and Welfare 330 Independence Ave., S.W., Room 4059 Washington, D.C. 20201
JIM COSSE	Research Assistant Department of Pscyhology Teachers College Columbia University 525 West 120th St., Box 164 New York, NY 10027
THOMAS CRUZ	Director of the Narcotic Addicts Rehabilitation Act Program Southwest Denver Community Mental Health Services, Inc. 3052 West Mississippi Ave. Denver, Colorado 80219
G. G. DeANGELIS	Treatment, Rehabilitation & Training Consultant Vitam Center, Inc. 57 West Rocks Road Norwalk, Conn. 06851
CHARLES ELLIOTT	Assistant Coordinator Vocational Rehabilitation 1616 Missouri Blvd. Jefferson City, Mo. 65101
MARY ETHRIDGE	Vocational Rehabilitation Counselor Oregon State Mental Health Division 309 Southwest 4th Avenue Portland, Oregon 97204

TOBY FAIRES	Director, Rehabilitation Services Texas Research Institute of Mental Sciences 1300 Moursand Avenue Houston, Texas 77025
STANLEY FEINBERG	Rehabilitation Counselor Office of Vocational Rehabilitation The State Education Department 1000 Franklin Ave. Garden City, Long Island, NY 11530
SANFORD FEINGLASS	Director, Institute for Social Concerns PO Box 9945 Mills College Oakland, Ca. 94613
WILLIAM FLETCHER	Program Supervisor Division of Health & Rehabilitation Department of Vocational Rehabilitation 254 Charley John Bldg. Tallahassee, Flo. 32304
DAVID FRANKLIN	Associate Director of Regional Research Institute in Social Welfare School of Social Welfare University of Southern California University Park Los Angeles, Ca. 90007
WILLIAM GREGOR	AFL-CIO Local No. 2869 United Steelworkers of America Fontana, Ca.
MICHAEL GOLD	Project Director Jewish Employment Vocational Service 1913 Walnut Street Philadelphia, Penn. 19103
I. IRA GOLDENBERG	Associate Professor of Clinical Psychology & Public Practice Graduate School of Education Harvard University Cambridge, Mass. 02138
HELEN DUNN GOUIN	Director, National Drug Education Center University of Oklahoma Medical Center 820 N.E. 15th St. Oklahoma City, Oklahoma 73104
ROBERT GRAHAM	Second Vice President & Medical Director Equitable Life Assurance of US 1285 Avenue of the Americas New York, NY 10019
ARTHUR JOHNSON	Coordinator of Inter-Agency Programs Division for Research & Training in Rehabilitation University of Southern California School of Medicine 1739 Griffin Ave. Los Angeles, Ca. 90031

BILL JOHNSON	Rehabilitation Services Representative Rehabilitation Services Administration Social & Rehabilitation Services Department of Health, Education, & Welfare 50 Fulton St. San Francisco, CA 94102
HENRY KAVKEWITZ	Director of Psychological Consultation Center Department of Psychology Teachers College Columbia University 525 West 120th St., Box 111 New York, NY 10027
FRED KELLY	Staff Advisor, Community Planning Office of Deputy Director of Priority Program Dept. of Health, Education & Welfare Social & Rehabilitation Services HEW South Bldg., Room 5122 Washington, D.C. 20201
BRYAN KEMP	Coordinator of Research Vocational Services Rancho Los Amigos Hospital 7601 E. Imperial Highway Downey, Ca. 90242
JOSEPH KUNCE	Project Director & Professor of Education Regional Rehabilitation Research Institute University of Missouri 223 South 5th Street Columbia, Mo. 65201
HERBERT LEIBOWITZ	Research & Demonstration Specialist Social & Rehabilitation Services Dept. of Health, Education, & Welfare 50 Fulton St., Room 352 San Francisco, Ca. 94102
ROSE LEOPOLD	Vocational Counselor Vocational Rehabilitation Division Dept. of Human Resources 309 Southwest 4th Avenue Portland, Oregon 97204
PAUL LEUNG	Assistant Professor The Rehabilitation Center College of Education University of Arizona Tucson, Arizona 85721
WENDELL LIPSCOMB	Executive Director Source, Inc: Studies of Urban Research and Community Education Suite B, 1918 Bonita St. Berkeley, Ca. 94704
ARLENE LISSNER	Assistant Director of Program Development and Training Illinois State Drug Abuse Program 1440 South Indiana Chicago, Ill. 60605

STUART LOOMIS	Director of the Psychological Services Section Haight-Ashbury Free Medical Clinic 409 Clayton St. San Francisco, Ca. 94117
IRVING LUKOFF	Director, Addiction Research & Treatment Corporation Evaluation Team Columbia University School of Social Work 622 West 113th St. New York, NY 10025
LLOYD MACK	Chief of Planning, Research & Program Development Department of Vocational Rehabilitation Union Federal Bldg., Room 201 309 North Curry Reno, Nevada 89701
GREGORY MARCH	Program Analyst Rehabilitation Services Administration Social & Rehabilitation Services Dept. of Health, Education & Welfare Mary Switzer Bldg., Room 3325 Washington, D.C. 20201
ROBERT MARKEL	Rehabilitation Counselor Division of Rehabilitation Services Maryland Plaza Building 1325 South 72nd St., Room 100B Omaha, Nebraska 68124
ROBERT MARX	Program Specialist for Drug Abuse Texas Rehabilitation Commission 1600 West 38th St. Austin, Texas 78705
RICHARD MONTES	Job Developer Boyle Heights Center 501 Echandia St. Los Angeles, Ca. 90033
WILLIAM MORGAN	Vocational Rehabilitation Program Specialist Rehabilitation Services Administration Social & Rehabilitation Services Dept. of Health, Education, & Welfare Box 13716 7760 Gateway Bldg., 3rd floor Philadelphia, Penn. 19101
LOIS MUNSON	Counselor Veteran's Administration Hospital Ward 105B2 3805 Miranda Palo Alto, Ca. 94304
ROGER MYERS	Professor of Psychology & Education & Associate Director Program Coordinator of Counseling & Personnel Teachers College Columbia University Box 164, 525 West 120th St. New York, NY 10027

LOUIS NAU	Special Assistant to the Commissioner Rehabilitation Services Administration DHEW South Bldg., Room 3110 330 Independence Avenue Washington, D.C. 20201
DAVID NURCO	Research Scientist Dept. of Mental Hygiene Maryland Psychiatric Research Center Drug Abuse Study 1229 W. Mount Royal Avenue Baltimore, Md. 21217
JOSEPH PALEVSKY	Associate Rehabilitation Counselor Office of Vocational Rehabilitation State Education Department 225 Park Ave., South New York, NY 10003
JANET PENCE	Rehabilitation Counselor Dept. of Vocational Rehabilitation 1299 4th St. San Rafael, Ca. 94901
DON PERKINS	Chief Resource Manager Resource Division Unit Division of Rehabilitation Education & Services Branch 801 Bankers Trust Bldg. Des Moines, Iowa 50309
ADELE PILSK	Coordinator, Drug Abuse, Editorial Seminar 50 Fulton St., Room 342 San Francisco, Ca. 94102
FATHER JIM REARDON	Group Therapist State Industrial School Mandan, North Dakota 58554
CHARLES REEDER	Research Assistant Regional Rehabilitation Research Institute University of Missouri 223 S. 5th Street Columbia, Mo. 65201
BILL REINER	Vocational Services Counselor Marin Open House 918 "C" Street San Rafael, Ca. 94901
ROSE ROBINSON	Social Science Analyst Division of Rehabilitation & Employability Research Research & Demonstration Social & Rehabilitation Services Dept. of Health, Education & Welfare Room 5327 HEW South Bldg. 330 "C" Street Washington, D.C. 20201

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JOSEPH ROTHSTEIN	Director, Office of Addictive Programs Office of the Governor State Capitol Bldg. Helena, Montana 59601
DANIEL SANFORD	Rehabilitation Counselor Office of Vocational Rehabilitation University of New York State Education Department 225 Park Ave. South New York, NY 10003
PHILIP SCHAFER	Regional Commissioner Social & Rehabilitation Services Dept. of Health, Education, & Welfare 50 Fulton St., Room 450 San Francisco, Ca. 94102
EDWARD SCOTT	Clinical Director Oregon State Mental Health Division 309 Southwest 4th Avenue Portland, Oregon 97204
FLORENCE SEAMAN	Project Officer National Institute for Mental Health Room 13-C-05 5600 Fischer Lane Rockville, Md. 20852
SOL SILVERMAN	Special Assistant to the Director for Formula Grants Division of Narcotic Addiction & Drug Abuse National Institute of Mental Health 5600 Fishers Lane Rockville, Md. 20852
HAROLD SIMMONS	Social Rehabilitation Services Specialist Division of Local Programs Dept. of Mental Hygiene 744 "P" Street Sacramento, Ca. 95814
JIM SINGLETON	Business Manager of Medical Clinic Haight Ashbury Free Medical Clinic 558 Clayton St. San Francisco, Ca. 94117
DAVID SMITH	Chairman of the Advisory Council of the Drug Abuse Editorial Seminar Medical Director of the Haight-Ashbury Free Medical Clinic 1698 Haight St. San Francisco, Ca. 94117
DONALD SUPER	Director of Division & Chairman of the Dept. of Psychology Teachers College Columbia University Box 214, 525 West 120th St. New York, NY 10027

CHARLOTTE TAYLOR	Director of Training Division for Research & Training in Rehabilitation University of Southern California School of Medicine 1739 Griffin Ave. Los Angeles, CA 90031
MARYANN URBAN	Program Director National Commission on Marijuana & Drug Abuse 801 19th St., N.W. Washington, D.C. 20006
HUGH W. WARD	PACT 415 Madison Avenue New York, N.Y. 10017
EDWARD WASHINGTON	Director, Model Neighborhood Inner City Drug Abuse Program 4707-15 Woodward Ave. Detroit, Michigan 48201
LEONA JACOBS-WHITE	Director, Social Rehabilitation Section "Crackerjack," Haight Ashbury Free Medical Clinic 1644 Haight St. San Francisco, Ca. 94117
EILEEN WOLKSTEIN	Chief, Vocational Rehabilitation Beth Israel Medical Center Beth Israel Hospital Morris J. Berstein Institute 307 Second Ave. New York, NY 10003
PEGGY WOODRUFF	Director of Vocational Services Marin Open House 918 "C" Street San Rafael, Ca. 94901
PATRICIA WRIGHT	Social Science Analyst Community Services Administration Social & Rehabilitation Services Dept. of Health, Education, & Welfare Room 2125 HEW South Bldg. 330 "C" Street, SW Washington, D.C. 20201
PAUL WRIGHT	Coordinator—Addiction, Alcoholism Correction Vocational Rehabilitation Box 1016 Lansing, Michigan 48904
THAYNE WRIGHT	Program Coordinator, Medical Social Work Vocational Rehabilitation Services Division Dept. of Social & Health Services P.O. Box 1788 MS 24-2 Olympia, Washington 98504
WILLIAM WRIGHT	Counselor, Dept. of Vocational Rehabilitation Area 5 Special Programs 117 Richmond, N.E. Albuquerque, New Mexico 87106